DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 440, 441, 482, 485, and 489

[CMS–1498–P]

RIN 0938–AP80

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals Under Age 21

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. These proposed changes would be applicable to discharges occurring on or after October 1, 2010. We also are setting forth the proposed update to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The proposed updated rate-of-increase limits would be effective for cost reporting periods beginning on or after October 1, 2010.

We are proposing to update the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). In the Addendum to this proposed rule, we also set forth the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS. These proposed changes would be applicable to discharges occurring on or after October 1, 2010.

We are proposing changes affecting the Medicare conditions of participation for hospitals relating to the types of practitioners who may provide rehabilitation services and respiratory care services.

We are proposing changes affecting the determination of the effective date of provider agreements and supplier approvals under Medicare.

Finally, we are proposing to offer psychiatric hospitals, hospitals with inpatient psychiatric programs, and psychiatric facilities that are not hospitals increased flexibility in obtaining accreditation to participate in the Medicaid program. Psychiatric hospitals would have the choice of meeting the existing regulatory requirements to participate in Medicare as a psychiatric hospital or to obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the existing regulatory requirements for participation in Medicare as a hospital or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. In addition, psychiatric facilities that are not hospitals would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

DATES: To be assured consideration, comments on this proposed rule must be received at one of the addresses provided below, no later than 5 p.m. Eastern Daylight Time (E.D.T.) on June 18, 2010.

ADDRESSES: When commenting on issues presented in this proposed rule, please refer to file code CMS–1498–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation at *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" and enter the file code CMS–1498–P to submit comments on this proposed rule.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1498–P, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1498–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

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

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

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

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

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

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

James Poyer, (410) 786–2261, Reporting of Hospital Quality Data for Annual Payment Update—Program Administration, Validation, and Reconsideration Issues.

Shaheen Halim, (410) 786–0641, Reporting of Hospital Quality Data for Annual Payment Update—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems.

Elizabeth Goldstein, (410) 786–6665 Reporting of Hospital Quality Data for Annual Payment Update—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Marcia Newton, (410–786–5265) and CDR Scott Cooper (U.S. Public Health Service), (410) 786–9465, Hospital Conditions of Participation for Rehabilitation Services and Respiratory Therapy Care Issues.

Marilyn Dahl, (410) 786–8665, Provider Agreement and Supplier Approval Issues.

Melissa Harris, (410) 786–3397 or Adrienne Delozier, (410) 786–0278, Accreditation of Providers of Inpatient Psychiatric Services to Individuals under Age 21 Issues.

SUPPLEMENTARY INFORMATION:

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

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

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Acronyms

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

IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LOS Length of stay
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Pub. L. 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MRSA Methicillin-resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NALTH National Association of Long Term Hospitals
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NP Nurse practitioner
NQF National Quality Forum
NTIS National Technical Information Service
NTTAA National Technology Transfer and Advancement Act of 1991 (Pub. L. 104–113)
NVHRI National Voluntary Hospital Reporting Initiative
OACT [CMS'] Office of the Actuary
OBRA 86 Omnibus Budget Reconciliation Act of 1996, Pub. L. 99–509
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
OPM U.S. Office of Personnel Management
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
PA Physician assistant
PIP Periodic interim payment
PLI Professional liability insurance
PMSAs Primary metropolitan statistical areas
POA Present on admission
PPACA Patient Protection and Affordable Care Act, Pub. L. 111–148
PPI Producer price index
PPS Prospective payment system
PRM Provider Reimbursement Manual
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PRTFs Psychiatric residential treatment facilities
PSF Provider-Specific File
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RCE Reasonable compensation equivalent
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution
RPL Rehabilitation psychiatric long-term care (hospital)
RRC Rural referral center
RTI Research Triangle Institute, International
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSN Social Security number
SSO Short-stay outlier
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TEP Technical expert panel
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Pub. L. 110–90
UHDDS Uniform hospital discharge data set

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Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2010

I. Background

A. Summary

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

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

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

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

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

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

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

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate based on their costs in a base year. For example, sole community

hospitals (SCHs) receive the higher of a hospital-specific rate based on their costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on the standardized amount. Through and including FY 2006, a Medicare-dependent, small rural hospital (MDH) received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate. SCHs are the sole source of care in their areas, and MDHs are a major source of care for Medicare beneficiaries in their areas. Specifically, section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. In addition, certain rural hospitals previously designated by the Secretary as essential access community hospitals are considered SCHs. Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years). Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries.

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

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

2. Hospitals and Hospital Units Excluded From the IPPS

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

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

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

The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS was established under the authority of sections 123(a) and (c) of Public Law 106–113 and section 307(b)(1) of Public Law 106–554 (as codified under section 1886(m)(1) of the Act). During the 5-year (optional) transition period, a LTCH's payment under the PPS was based on an increasing proportion of the LTCH Federal rate with a corresponding decreasing proportion based on reasonable cost principles. Effective for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, Subpart O. Beginning October 1, 2009, we issue the annual updates to the LTCH PPS in the same documents that update the IPPS (73 FR 26797 through 26798).

4. Critical Access Hospitals (CAHs)

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

5. Payments for Graduate Medical Education (GME)

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

B. Provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as Amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new

legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

C. Major Content of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2011. We also are setting forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis.

In addition, in this proposed rule, we are setting forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011. We note that because the annual update of payment rates for the LTCH PPS will now take place on the same schedule and in the same publication as for the IPPS, for the sake of clarity, in section VII.D. of this proposed rule, we are proposing to use "fiscal year (FY)" instead of "rate year (RY) when referring to updates and changes to the LTCH PPS to be effective October 1, 2010. Therefore, throughout this proposed rule, we are using the phrase "fiscal year (FY)" in referring to proposed updates and changes to the LTCH PPS.

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

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

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

- Proposed changes to MS–DRG classifications based on our yearly review.
- Proposed application of the documentation and coding adjustment to hospital-specific rates for FY 2011 resulting from implementation of the MS–DRG system.
- A discussion of the Research Triangle International, Inc. (RTI) and RAND Corporation reports and recommendations relating to charge compression.
- Proposed recalibrations of the MS–DRG relative weights.

We also presented a listing and discussion of hospital-acquired conditions (HACs), including infections, that are subject to the statutorily required quality adjustment in MS–DRG payments for FY 2011.

We discuss the FY 2011 status of two new technologies approved for add-on payments for FY 2010 and presented our evaluation and analysis of the FY 2011 applicants for add-on payments for high-cost new medical services and technologies (including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

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

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

- Budget neutrality for the rural floor and imputed floor.
- Changes to titles and principal cities of CBSA designations.
- The proposed FY 2011 wage index update using wage data from cost reporting periods beginning in FY 2007.
- Analysis and implementation of the proposed FY 2011 occupational mix adjustment to the wage index for acute care hospitals, including discussion of the 2010 occupational mix survey.
- Proposed revisions to the wage index for acute care hospitals based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for acute care hospitals for FY 2011 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data used to compute the proposed FY 2011 hospital wage index.
- Determination of the labor-related share for the proposed FY 2011 wage index.

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

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

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Payment for transfer cases from Medicare participating hospitals to nonparticipating hospitals and CAHs.
- A change to the definition criteria for MDHs.
- The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status.
- The statutorily required IME adjustment factor for FY 2011.
- The proposed policy change relating to the determination of the SSI ratio of the Medicare fraction in the formula for determining the payment adjustments for disproportionate share hospitals.
- A proposed clarification of "approved medical residency programs" policies relating to payment for IME and direct GME and our proposal to accept the electronic submission of Medicare GME affiliation agreements.
- Proposed policy change for payments for services furnished by certified registered nurse anesthetists (CRNAs) in rural hospitals and CAHs.
- Discussion of the status of the Rural Community Hospital Demonstration Program.

4. Proposed FY 2011 Policy Governing the IPPS for Capital-Related Costs

In section V. of the preamble to this proposed rule, we discussed the proposed payment policy requirements for capital-related costs and capital payments to hospitals for FY 2011 and the proposed MS–DRG documentation and coding adjustment for FY 2011.

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

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

- Proposed changes to payments to excluded hospitals.
- Proposed changes relating to the election by CAHs of the optional method of payment for outpatient services
- Proposed clarification of the policies on costs of provider taxes as allowable costs for CAHs.

6. Proposed Changes to the LTCH PPS

In section VII. of the preamble of this proposed rule, we set forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011, including the annual update of the MS–LTC–DRG classifications and relative weights for use under the LTCH PPS for FY 2011 and the proposed MS–DRG documentation and coding adjustment for FY 2011.

7. Proposed Changes Relating to Effective Date of Provider Agreements and Supplier Approvals

In section VIII. of the preamble of this proposed rule, we set forth our proposed change in policies for

determining the effective date of provider agreements and supplier approvals and to make changes to assure that accredited and nonaccredited facilities are treated in the same manner in determining this effective date.

8. Proposed Changes to Medicare Conditions of Participation Affecting Hospital Rehabilitation Services and Respiratory Care Services

In section IX. of the preamble of this proposed rule, we are proposing changes to the Medicare conditions of participation regarding which practitioners are allowed to order rehabilitation and respiratory care services in the hospital setting.

9. Proposed Changes to the Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals under Age 21

In section X. of the preamble of this proposed rule, we are proposing to remove the requirement for accreditation by The Joint Commission of psychiatric hospitals and hospitals with inpatient psychiatric programs. Hospitals with inpatient psychiatric programs would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose hospital accrediting program has been approved by CMS, and psychiatric rehabilitation treatment facilities would be afforded flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

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

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2011 prospective payment rates for operating costs and capital-related costs for acute care hospitals. We also are establishing the proposed threshold amounts for outlier cases. In addition, we address the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2011 for certain hospitals excluded from the IPPS.

11. Determining Proposed Prospective Payment Rates for LTCHs

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2011 prospective standard Federal rate. We also are establishing the proposed adjustments for wage levels, the labor-related share, the cost-of-living adjustment, and high-cost outliers, including the fixed-loss amount, and the LTCH cost-to-charge ratios (CCRs) under the LTCH PPS.

12. Impact Analysis

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

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

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provide our recommendations of the appropriate percentage changes for FY 2011 for the following:

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

14. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2010 recommendations concerning hospital inpatient payment policies address the update factor for hospital inpatient operating costs and capital-related costs under the IPPS, for hospitals and distinct part hospital units excluded from the IPPS. We address these recommendations in Appendix B of this proposed rule. For further information relating specifically to the MedPAC March 2008 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov.*

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

Section 4302 of the American Recovery and Reinvestment Act of 2009 (ARRA, Public Law 111–5) included several amendments to section 114 of Public Law 110–173 (MMSEA) relating to payments to LTCHs and LTCH satellite facilities that were discussed under section X. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43976 through 43990). These amendments are effective as if they were enacted as part of section 114 of Public Law 110–173 (MMSEA). We issued instructions to the fiscal intermediaries and Medicare administrative contractors (MACs) to interpret these amendments (Change Request 6444). In section XI. of the FY 2010/RY 2010 LTCH PPS final rule (74 FR 43990), we implemented the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period. We will respond to the public comments that we received in a timely manner on this interim final rule with comment period and finalize the interim final rule with any necessary modification in the final rule for this proposed rule.

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

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These

adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

B. MS–DRG Reclassifications

1. General

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

Currently, cases are classified into MS–DRGs for payment under the IPPS based on the following information reported by the hospital: The principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. (We refer readers to section II.G.11.c. of this proposed rule for a discussion of our efforts to increase our internal systems capacity to process diagnosis and procedures on hospital claims to 25 diagnosis codes and 25 procedure codes prior to the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10 PCS) for inpatient hospital procedure coding, effective October 1, 2013.) In a small number of MS–DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) prior to October 1, 2013. We refer readers to section II.G.11.b. of this proposed rule for a reference to the replacement of ICD–9–CM, Volumes 1 and 2, including the Official ICD–9–CM Guidelines for Coding and Reporting, Volume 3, with the ICD–10–CM and ICD–10–PCS, including the Official ICD–10–CM and ICM–10–PCS Guidelines for Coding and Reporting, effective October 1, 2013 (FY 2014).

The process of developing the MS–DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formulated by physician panels to ensure that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final MS–DRG could contain patients in different MDCs. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2010, cases are assigned to one of 746 MS–DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.
24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

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

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to an MS–DRG. However, under the most recent version of the Medicare GROUPER (Version 27.0), there are 13 MS–DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These MS–DRGs are for heart transplant or implant of heart assist systems; liver and/or intestinal transplants; bone marrow transplants; lung transplants; simultaneous pancreas/kidney transplants; pancreas transplants; and tracheostomies. Cases are assigned to these MS–DRGs before they are classified to an MDC. The table below lists the 13 current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

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

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

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

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

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

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

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

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

As we indicated above, for FY 2008, we made significant improvements in the DRG system to recognize severity of illness and resource usage by adopting MS–DRGs that were reflected in the FY 2008 GROUPER, Version 25.0, and were effective for discharges occurring on or after October 1, 2007. Our MS–DRG analysis for the FY 2009 final rule was based on data from the March 2008 update of the FY 2007 MedPAR file, which contained hospital bills received through March 31, 2008, for discharges occurring through September 30, 2007. For this proposed rule, for FY 2011, our MS–DRG analysis is based on data from the September 2009 update of the FY 2009 MedPAR file, which contains hospital bills received through September 30, 2009, for discharges occurring through September 30, 2009.

2. Yearly Review for Making MS–DRG Changes

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

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

C. Adoption of the MS–DRGs in FY 2008

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

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

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

In the FY 2007 IPPS final rule (71 FR 47898), we indicated our intent to pursue further DRG reform through two initiatives. First, we announced that we were in the process of engaging a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the CMS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's in connection with adopting severity DRGs. We describe below the progress we have made on these two initiatives and our actions for FYs 2008, 2009, and 2010, and our proposals for FY 2011 based on our continued analysis of reform of the DRG system. We note that the adoption of the MS–DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these implications for FY 2011 in other sections of this preamble and in the Addendum to this proposed rule.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY

2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) which we then applied to charges on the Medicare claims to determine the cost-based weights. The commenters were concerned about potential distortions to the cost-based weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International (RTI) to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this proposed rule for discussion of the issue of charge compression and the cost-weighting methodology for FY 2011.

We believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of the payment rates in the IPPS. We agree with MedPAC that these refinements should be pursued. Although we continue to caution that any prospective payment system based on grouping cases will always present some opportunities for providers to specialize in cases they believe have higher margins, we believe that the changes we have adopted and the continuing reforms we are proposing to make in this proposed rule for FY 2011 will improve payment accuracy and reduce financial incentives to create specialty hospitals.

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

D. Proposed FY 2011 MS–DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount

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

As we discussed earlier in this preamble, we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. (Currently, there are 746 DRGs for FY 2010; there would be 747 DRGs in FY 2011, with our proposals in this proposed rule to delete one MS–DRG and to create two new MS–DRGs.) By increasing the number of MS–DRGs and more fully taking into account patients' severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule with comment period, we exercised our authority under section 1886(d)(3)(A)(vi) of the Act, which authorizes us to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. Our actuaries estimated that maintaining budget neutrality required an adjustment of −4.8 percent to the national standardized amount. We provided for phasing in this −4.8 percent adjustment over 3 years. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010.

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

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

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

Section 7(b)(1)(A) of Public Law 110–90 requires that, if the Secretary determines that implementation of the

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

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

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

4. Retrospective Evaluation of FY 2008 Claims Data

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

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

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

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

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

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

implementation of the payment adjustments beginning in FY 2010.

We took these comments into consideration as we developed our proposed analysis plan and in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24092 through 24101) solicited public comment on our methodology and analysis. For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries determined that implementation of the MS–DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008

In the analysis of data for that proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change, supporting our conclusion that the 2.5 percent estimate was an accurate reflection of the FY 2008 effect of changes in documentation and coding under the MS–DRG system. In fact, almost every base DRG that was split into different severity levels under the MS–DRG system experienced increases in the within-base DRGs. We then further analyzed the changes in the within-base DRGs to determine which MS–DRGs had the highest contributions to this increase. The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 2.5 percent estimate accurately reflected the FY 2008 increases in documentation and coding under the MS–DRG system. While we attempted to use the CDAC data to distinguish real increase in case-mix growth from documentation and coding in the overall case-mix number, we found aberrant data and significant variation across the FY 1999 through FY 2007 analysis period. It was not possible to distinguish changes in documentation and coding from changes in real case-mix in the CDAC data. Therefore, we concluded that the CDAC data would not support analysis of real case-mix growth that could be used in our retrospective evaluation of the FY 2008 claims data.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43768 through 43772), we responded to comments on our methodology for the retrospective evaluation of FY 2008 claims data. Commenters raised concerns that CMS' estimate in the proposed rule did not fully consider other potential causes of increased case-mix, such as patients requiring less complex services receiving care in other settings and "healthier" patients enrolling in Medicare Advantage plans in increasing numbers. Other commenters indicated that factors such as the changes in the CC/MCC definitions, limitations on the number of codes used by CMS for payment and ratesetting, resequencing of secondary diagnoses, the transition to the cost-based weights, less use of "not otherwise specified" codes, and increases in real case-mix due to health reform efforts also resulted in an inaccurate documentation and coding analysis. One commenter indicated that, of the overall case-mix increase, 1.0 percent to 1.5 percent is "real" case-mix increase, while 1.0 percent to 1.5 percent is due to documentation and coding or other increases.

In considering these comments concerning historical real case-mix, in the FY 2010 final rule, we calculated overall increases in case-mix for the period from FY 2000 to FY 2007 using the cases from each year and the GROUPER and relative weights applicable for each year. The results are shown in the following chart:

OVERALL CASE-MIX INCREASES FOR FY 2000 TO FY 2007

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

Overall case-mix growth is predominately comprised of three factors: Real case-mix growth; a documentation and coding effect; and a measurement effect. Under the reasonable assumption that there has been a relatively small measurement effect in those years, the assertion that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case-mix implies that the documentation and coding effect in many of those years was negative. For example, as discussed in that rule (74 FR 43769), we estimated a recent measurement effect of +0.3 percent. The overall case-mix growth of −0.2 percent in FY 2007 net of a measurement effect of +0.3 percent results in growth of +0.1 percent. A real case-mix growth of +1.2 percent in FY 2007, therefore, implies a negative documentation and coding effect of approximately −1.1 percent. It is not obvious why documentation and coding would have had such a large negative effect in FY 2007, or in any other year where the overall case-mix change is significantly less than the commenter's claimed average annual trend, calling into question the assertion that real case-mix growth is a steady 1.2 to 1.3 percent per year.

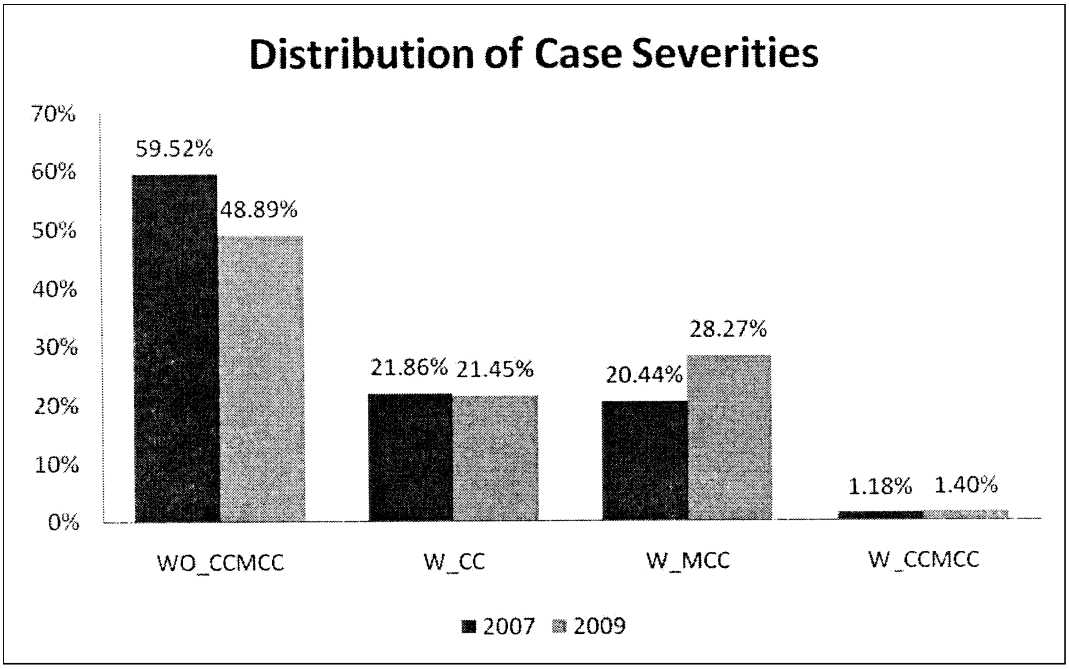
In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43770 through 43771), we indicated that our estimate of the overall case-mix growth for FY 2008 based on more recent data than the data used in the FY 2010 proposed rule was 2.0 percent, still less than our actuaries' estimate of a 2.5 percent documentation and coding increase. With respect to the concerns raised by commenters about our finding of negative real case-mix growth in FY 2008, a finding of negative real case-mix growth is consistent with the fact that, in some years, overall case-mix growth has been negative, as shown in the chart presented above in this response.

5. Retrospective Analysis of FY 2009 Claims Data

We performed the same analysis for FY 2009 claims data using the same methodology as we did for FY 2008 claims in the FY 2010 final rule. We first divided the case-mix index (CMI) obtained by grouping the FY 2009 claims data through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same FY 2009 claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.056. Because these cases are the same FY 2009 cases grouped using the Versions 24.0 and 26.0 of the GROUPER, we attribute this increase primarily to two factors: (1) The effect of changes in documentation and coding under the MS–DRG system; and (2) the measurement effect from the calibration of the GROUPER. We estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping cases in the FY 2007 claims data through the FY 2009 GROUPER by the CMI obtained by grouping cases in these same claims through the FY 2007 GROUPER. This resulted in a value of 1.0019. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding and measurement (1.056) by the measurement effect (1.0019) to yield 1.054. Therefore, our estimate of the documentation and coding increase that did not reflect real changes in case-mix for discharges was 5.4 percent.

We then sought to corroborate this 5.4 percent estimate by examining the increases in the within-base DRGs as compared to the increases in the across

base DRGs as described earlier in our analysis plan. In other words, we looked for improvements in code selection that would lead to a secondary diagnosis increasing the severity level to either a CC or an MCC level. We found that the within-base DRG increases were almost entirely responsible for the case mix change, supporting our conclusion that the 5.4 percent estimate was an accurate reflection of the FY 2009 effect of changes in documentation and coding under the MS–DRG system. We then further analyzed the changes in the within-base DRGs to determine which MS–DRGs had the highest contributions to this increase. The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 5.4 percent estimate accurately reflected the FY 2009 increases in documentation and coding under the MS–DRG system.



As reflected in the above chart, for short-term acute care hospitals, SCHs, and MDHs, there is an 8 percentage point increase in the discharge severity with MCCs from 20 percent to 28 percent, and a corresponding decrease of 8 percentage points in discharge severity without CC/MCC from 57 percent to 49 percent.

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

The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 5.4 percent estimate accurately reflected the FY 2009 increases in documentation and coding under the MS–DRG system.

As in prior years, the FY 2008 and FY 2009 MedPAR files are available to the public to allow independent analysis of the FY 2008 and FY 2009 documentation and coding effect. Interested individuals may still order these files through the Web site at: *http://www.cms.hhs.gov/LimitedDataSets/* by clicking on MedPAR Limited Data Set (LDS)-Hospital (National). This Web page describes the file and provides directions and further detailed instructions for how to order.

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

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

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

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

Based on our evaluation of FY 2008 Medicare claims data that were most current at the time of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, the estimated 2.5 percent change in FY 2008 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeded the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Under section 7(b)(1)(A) of Public Law 119–90,

the Secretary is required to make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act to the average standardized amounts for subsequent fiscal years in order to eliminate the full effect of the documentation and coding changes on future payments. As we have consistently stated since the initial implementation of the MS–DRG system, we do not believe it is appropriate for expenditures to increase due to MS–DRG-related changes in documentation and coding that do not reflect real changes in case-mix.

We also estimated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that the additional change in case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009 was 2.3 percent, which would exceed by 1.4 percentage points the −0.9 percent prospective documentation and coding adjustment for FY 2009 applied under section 7(a) of Public Law 100–90. We had the statutory authority to adjust the FY 2010 rates for this estimated 1.4 percentage point increase. However, given that Public Law 100–90 requires a retrospective claims evaluation for the additional adjustments (as described in section II.D.3. of this preamble), we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule and final rule (74 FR 24096 and 43772, respectively) that we believed our evaluation of the extent of the overall national average changes in case-mix for FY 2009 should also be based on a retrospective evaluation of all FY 2009 claims data. Because we did not receive all FY 2009 claims data prior to publication of the FY 2010 final rule, we indicated we would address any difference between the additional increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24096), we solicited public comment on the proposed −1.9 percent prospective adjustment to the standardized amounts under section 1886(d) of the Act to address the effects of documentation and coding changes unrelated to changes in real case-mix in FY 2008. In addition, we solicited public comments on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to changes in documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90. In response to the proposed rule, MedPAC summarized its comments on when CMS should reduce payment rates to prevent further overpayments and to recover overpayments occurring in 2008 and 2009 as follows: "We support CMS's proposal to reduce IPPS payments in 2010 by 1.9 percent to prevent further overpayments. While we and the CMS actuaries believe that a 1.9 percent reduction will not fully prevent overpayments from continuing in 2010, this is a reasonable first step toward reducing overpayments." Most of the other commenters opposed the proposed −1.9 percent prospective FY 2010 adjustment for FY 2008 documentation and coding increases, but supported the proposal not to apply a FY 2010 prospective adjustment for estimated FY 2009 documentation and coding increases. Many commenters expressed concern over the financial impact of the proposed −1.9 percent adjustment and the methodology for calculating the adjustment. Other commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount.

In the final FY 2010 IPPS/RY 2010 LTCH PPS rule in response to these commenters, we indicated that we fully understood that our proposed adjustment of −1.9 percent would reduce the increase in payments that affected hospitals would have received in FY 2009 in the absence of the adjustment. We explained that, although we are required to make an prospective adjustment to eliminate the full effect of coding or classification changes that did not reflect real changes in case-mix for discharges occurring during FY 2008, we believed we had some discretion regarding when to implement this adjustment. Section 7(b)(1)(A) of Public Law 110–90 requires that if the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, the Secretary shall make an "appropriate" adjustment under section 1886(d)(3)(A)(vi) of the Act.

Thus, we determined that it would be appropriate to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of case-mix changes could be completed. We indicated that while we had the statutory authority to make this −1.9 percent prospective adjustment entirely in FY 2010, we believed it would be prudent to wait until we had completed data on the magnitude of the documentation and coding effect in FY 2009. Specifically, we stated that if the documentation and coding effect were to be less in FY 2009 than our then-current estimates, it could lessen the anticipated adjustment that we had estimated we would have had to make for FY 2008 and FY 2009 combined. We indicated that, in future rulemaking, we would consider applying a prospective adjustment based upon a complete analysis of FY 2008 and FY 2009 claims data, beginning in FY 2011. We indicated that we intended to address any difference between the increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

After analysis of the FY 2009 claims data, we have found a total prospective documentation and coding effect of 1.054. After accounting for the −0.6 percent and the −0.9 percent documentation and coding adjustments in FYs 2008 and 2009, we find a remaining documentation and coding effect of 3.9 percent. As we have discussed, an additional cumulative adjustment of −3.9 percent would be necessary to meet the requirements of section 7(b)(1)(A) of Public Law 110–90 to make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments. Unlike section 7(b)(1)(B) of Public Law 110–90, section 7(b)(1)(A) does not specify when we must apply the prospective adjustment, but merely requires us to make an "appropriate" adjustment. Therefore, we believe we have some discretion as to the manner in which we apply the prospective adjustment of −3.9 percent. Applying the full prospective adjustment of −3.9 percent for FY 2011, in combination with the proposed recoupment adjustment of −2.9 percent, discussed below, would require an aggregate adjustment of −6.8 percent. As we discuss more fully

below, it has been our practice to moderate payment adjustments when necessary to mitigate the effects of significant downward adjustments on hospitals, to avoid what could be widespread, disruptive effects of such adjustments on hospitals. As we also discuss below, we are required to implement the adjustment in section 7(b)(1)(B) of Public Law 110–90 no later than FY 2012, and accordingly, we are proposing an adjustment under that section for FY 2011. Therefore, we believe it is appropriate to not implement any or all of the −3.9 percent prospective adjustment in FY 2011. Accordingly, we are not proposing a prospective adjustment under section 7(b)(1)(A) of Public Law 110–90 for FY 2011. We note that, as a result, payments in FY 2011 (and in each future year until we implement the requisite adjustment) will be 3.9 percent higher than they would have been if we had implemented an adjustment under section 7(b)(1)(A) of Public Law 110–90.

We are seeking public comment on our proposal not to apply in FY 2011 the −3.9 percent prospective adjustment to the average standardized amounts required under section 7(b)(1)(A) of Public Law 110–90 in order to eliminate the full effect of the documentation and coding changes on future payments. We note that this proposal would require us to apply the −3.9 percent adjustment in future payment years, which may be applied all at once in a single year or phased in over more than one year. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

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

As indicated in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43773), we estimated a 2.5 percent change (estimated from analysis of more recent data for the FY 2010 final rule than the data used for that proposed rule) due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008, exceeding the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. We stated that our actuaries had estimated that this 1.9 percentage point increase resulted in an increase in aggregate payments of approximately $2.2 billion. As described earlier, section 7(b)(1)(B) of Public Law 110–90 requires an adjustment for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of this increase in aggregate payments (including interest). Although section 7(b)(1)(B) of Public Law 110–90 requires us to make this adjustment in FYs 2010, 2011, and/or 2012, we have discretion as to when during this 3 year period we will apply the adjustment.

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

As discussed above, section 7(b)(1)(B) of Public Law 110–90 requires the Secretary to make an adjustment to the standardized amounts under section 1886(d) of the Act to offset the estimated increase or decrease in aggregate payments for FY 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustments applied under section 7(a) of Public Law 110–90. This determination must be based on a retrospective evaluation of claims data. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43774), we stated that because we would not receive all FY 2009 claims data prior to publication of the final rule, we would address any increase or decrease in FY 2009 payments in future rulemaking for FY 2011 and 2012 after we perform a retrospective evaluation of the FY 2009 claims data. At that time, our actuaries estimated that this adjustment would be approximately −3.3 percent. This reflected the difference between the estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 (2.5 percent for FY 2008 and an additional 2.3 percent for FY 2009) and the cumulative −1.5 percent documentation and coding adjustments applied under section 7(a) of Public Law 110–90 (−0.6 percent in FY 2008 and −0.9 percent in FY 2009). We noted that the actual adjustments were multiplicative and not additive. This estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 included the impact of the changes in documentation and coding first occurring in FY 2008 because we believed hospitals would continue these changes in documentation and coding in subsequent fiscal years. Consequently, we believed that these documentation and coding changes would continue to impact payments under the IPPS absent a prospective adjustment to account for the effect of these changes.

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

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

In response to the FY 2010 proposed rule, MedPAC stated in its comments on the adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90: "In addition, it would be desirable for CMS to minimize year-to-year changes in payment adjustments it must make to recover overpayments that were made in 2008 and 2009. To achieve this goal, CMS should consider spreading the recovery of 2008 overpayments over 3 years, beginning in 2010." Some commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount. The commenters asked CMS to seek

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

In response to these comments in FY 2010, we indicated that we recognized that any adjustment to account for the documentation and coding effect observed in the FY 2008 and FY 2009 claims data may result in significant future payment reductions for providers. However, we indicated that we are required under section 7(b)(1)(B) of Public Law 110–90 to recapture the difference of actual documentation and coding effect in FY 2008 and FY 2009 that is greater than the prior adjustments. We agreed with the commenters who requested that CMS delay any adjustment and, for the reasons stated above, indicated that we expect to address this issue in this FY 2011 rulemaking.

As indicated in section II.D.4. of this preamble, the change due to documentation and coding that did not reflect real changes in case mix for discharges occurring during FY 2008 and FY 2009 exceeded the −0.6 and −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 for those 2 years respectively by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points. Our actuaries currently estimate that this 5.8 percentage point increase resulted in an increase in aggregate payments of approximately $6.9 billion. We note that there may be a need to actuarially adjust the recoupment adjustment to accurately reflect accumulated interest. Therefore, an aggregate adjustment of −5.8 percent in FYs 2011 and 2012, subject to actuarial adjustment to reflect accumulated interest, is necessary in order to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of the increase in aggregate payments (including interest) in FYs 2008 and 2009. We intend to take into account the need to reflect accumulated interest in proposing a recoupment adjustment under section (b)(1)(B) of Public Law 110–90 for FY 2012. We will invite comments on our proposal at that time.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, consistent with the policies we have adopted in many similar cases, we are proposing to make an adjustment to the standardized amount of −2.9 percent, representing approximately half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. An adjustment of this magnitude allows us to moderate the effects on hospitals in one year while simultaneously making it possible to implement the entire adjustment within the timeframe required under section 7(b)(1)(B) of Public Law 110–90. As we have previously noted, unlike the prospective adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, the recoupment or repayment adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures. In keeping with our practice of moderating payment adjustments wherever possible, we can anticipate that this proposal will have an additional, and significant, moderating effect on implementing the requirements of section 7(b)(1)(B) of Public Law 110–90 for FY 2012. Specifically, an advantage of our proposal for FY 2011 is that we anticipate removing this proposed FY 2011 −2.9 percent adjustment from the rates in FY 2012, when it would also be necessary under current law to apply the remaining approximately −2.9 percent adjustment required by section 7(b)(1)(B) of Public Law 110–90. These two steps in FY 2012, restoring the FY 2011 −2.9 percent adjustment, and applying the remaining adjustment of approximately −2.9 percent, would effectively cancel each other out. The result would be an aggregate adjustment of approximately 0.0 percent (subject to the need to account for accumulated interest, as discussed above) under section 7(b)(1)(B) of Public Law 110–90 in FY 2012. However, while we are noting this anticipated effect of our FY 2011 proposal, we are not making a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in this proposed rule.

We are seeking public comment on our proposal to offset part of the total 5.8 percent increase in aggregate payments (including interest) for discharges occurring in FY 2008 and FY 2009 resulting from the adoption of the MS–DRGs in FY 2011, noting that this proposal would result in a −2.9 percent adjustment to the standardized amount. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

FY 2011 MS–DRG Documentation and Coding Adjustment

	Required prospective adjustment for FYs 2008–2009	Required recoupment adjustment for FYs 2008–2009	Total adjustment	Proposed recoupment adjustment for FY 2011	Remaining adjustment
FY 2011 Proposal Amount of Adjustment	−3.9	−5.8	−9.7	−2.9	−6.8

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

Under section 1886(d)(5)(D)(i) of the Act, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge. Under

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

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

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

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

9. Proposed Documentation and Coding Adjustment to the Hospital-Specific Rates for FY 2011 and Subsequent Fiscal Years

In the FY 2010 IPPS/RY 2010 LTCH proposed rule and final rule (74 FR 24098 through 24100 and 74 FR 43775 through 43776, respectively), we discussed our performance of a retrospective evaluation of the FY 2008 claims data for SCHs and MDHs using the same methodology described earlier for other IPPS hospitals. We found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the proposed 2.5 percent result discussed earlier, but did not significantly differ from that result.

Again, for the FY 2010 proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change. In that proposed rule, we presented two Figures to display our results.

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

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24100), we solicited public comment on the proposed −2.5 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our proposal to address in the FY 2011 rulemaking cycle any changes in FY 2009 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009. We also indicated that we intended to update our analysis with FY 2008 data on claims paid through March 2008 [sic] for the FY 2010 IPPS final rule. (We note that the March 2008 update claims paid data date in the proposed rule should have been March 2009.)

Consistent with our approach for IPPS hospitals discussed earlier, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also delayed adoption of a documentation and coding adjustment to the hospital-specific rate until FY 2011. Similar to our approach for IPPS

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

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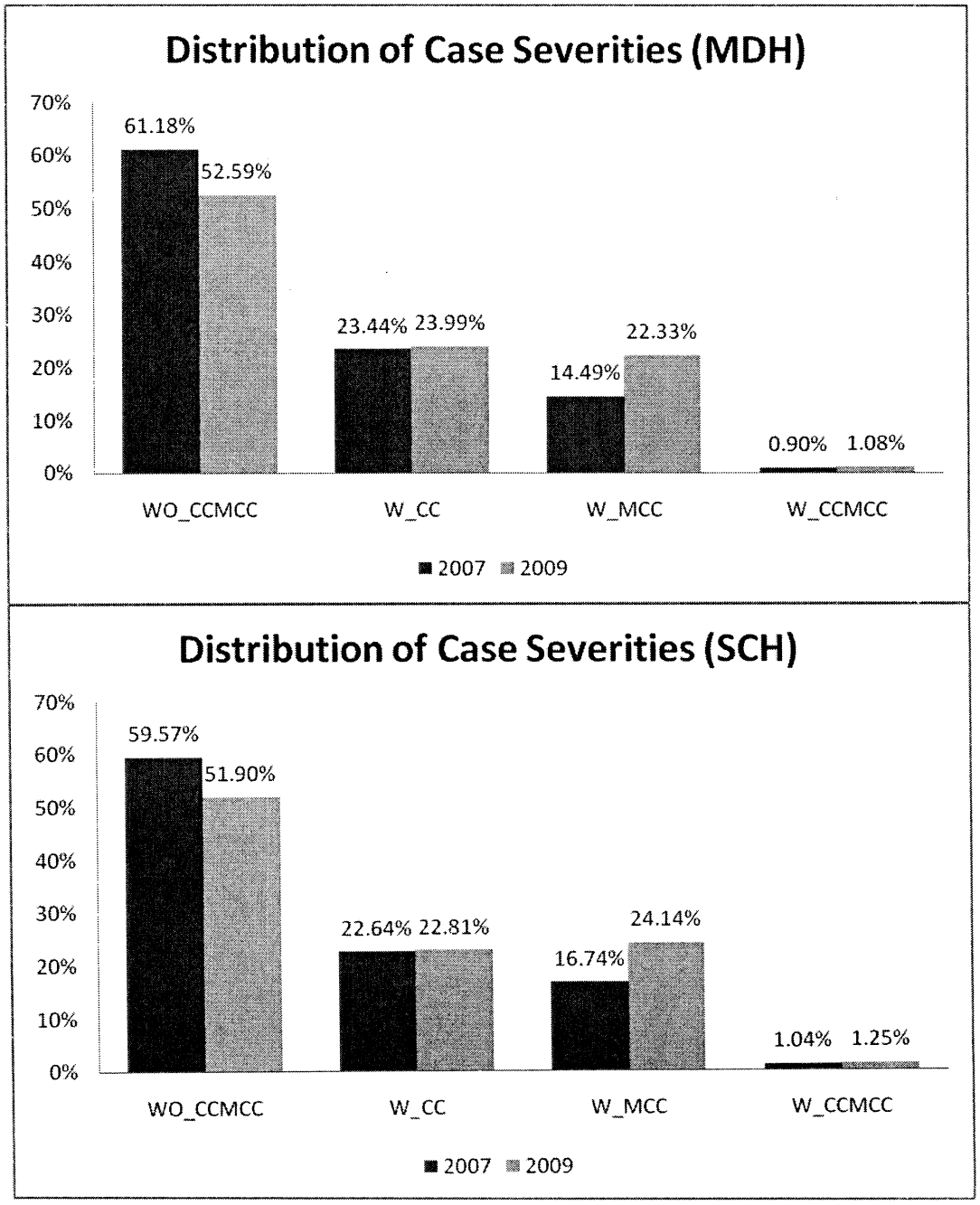

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Consistent with our analysis of IPPS hospitals, the two charts above show that we found after analysis of FY 2009 discharge data that the distribution of severity discharges for MDH and SCH both proportionally shifted from the

without CC/MCC to with MCC category. Similarly, we found using a methodology consistent with our analysis of IPPS hospitals that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 slightly exceeded the proposed 2.5 percent result discussed earlier, but did not significantly differ from that result.

As we have noted above, because SCHs and MDHs use the same MS–DRG system as all other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. We believe the documentation and coding estimates for all subsection (d) hospitals should be the same. While the findings for the documentation and coding effect for all IPPS hospitals are similar to the effect for SCHs and slightly different to the effect for MDHs, we continue to believe that this is the appropriate policy so as to neither advantage or disadvantage different types of providers. As we have also discussed above, our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire −5.4 percent adjustment remains to be implemented.

As discussed above, we are proposing to make an adjustment to the standardized amount for IPPS hospitals of −2.9 percent under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. As we also discussed above, it has been our practice to moderate payment adjustments when necessary to mitigate the effects of significant downward adjustments on hospitals, to avoid what could be widespread, disruptive effects of such adjustments on hospitals. Because payments for non-SCH and non-MDH IPPS hospitals and SCHs and MDHs are determined on the basis of the same MS–DRG system, SCHs and MDHs have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, in determining the level and pace of adjustments to account for such documentation and coding changes, we believe that it is important to maintain, as much as possible, both consistency and equity among these classes of hospitals. In addition, as in the case of the documentation and coding adjustment for non-SCH and non-MDH IPPS hospitals, we also believe that it is important to provide as much as possible for moderating the effects of adjustments on hospital payments. Therefore we are proposing an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. This proposal is consistent with our proposed adjustment for IPPS hospitals in two ways. First, as in the case of the IPPS adjustment, we are not proposing to implement the entire adjustment that is warranted by our data (in this case, 5.4 percent) in one year. Second, we are maintaining consistency by proposing the same numerical level of adjustment for both groups of hospitals in FY 2011. While this proposed adjustment to the hospital-specific rates represents somewhat over half of the of the entire adjustment that is appropriate for SCHs and MDHs, it allows us to maintain complete consistency, at least for FY 2011, in the effects on the relevant classes of hospitals. Although the proposed adjustment for SCHs and MDHs is cumulative and prospective, as opposed to the noncumulative recoupment adjustment we are proposing for other IPPS hospitals, we believe that proposing equal numerical adjustments in this first year is the most appropriate means to maintain such consistency and equity at this time. We will continue, as much as possible, consistent with sections 7(b)(1) of Public Law 110–90 and section 1886(d)(5)(I)(i) of the Act, to take such consistency and equity into account in developing future proposals for implementing documentation and coding adjustments.

We are seeking public comment on the proposed −2.9 percent prospective adjustment to hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and addressing in future rule making cycles changes in FY 2008 and FY 2009 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009, noting that our current estimates of the remaining adjustment is −2.5 percent. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

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

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

While section 1886(d)(3)(A)(vi) of the Act is not applicable to the Puerto Rico-specific standardized amount, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and

MDHs, in the FY 2009 IPPS final rule (73 FR 48449), we indicated that we planned to examine our FY 2008 claims data for hospitals in Puerto Rico. We indicated in the FY 2009 IPPS proposed rule (73 FR 23541) that if we found evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 Puerto Rico-specific standardized amount under our authority in section 1886(d)(5)(I)(i) of the Act.

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

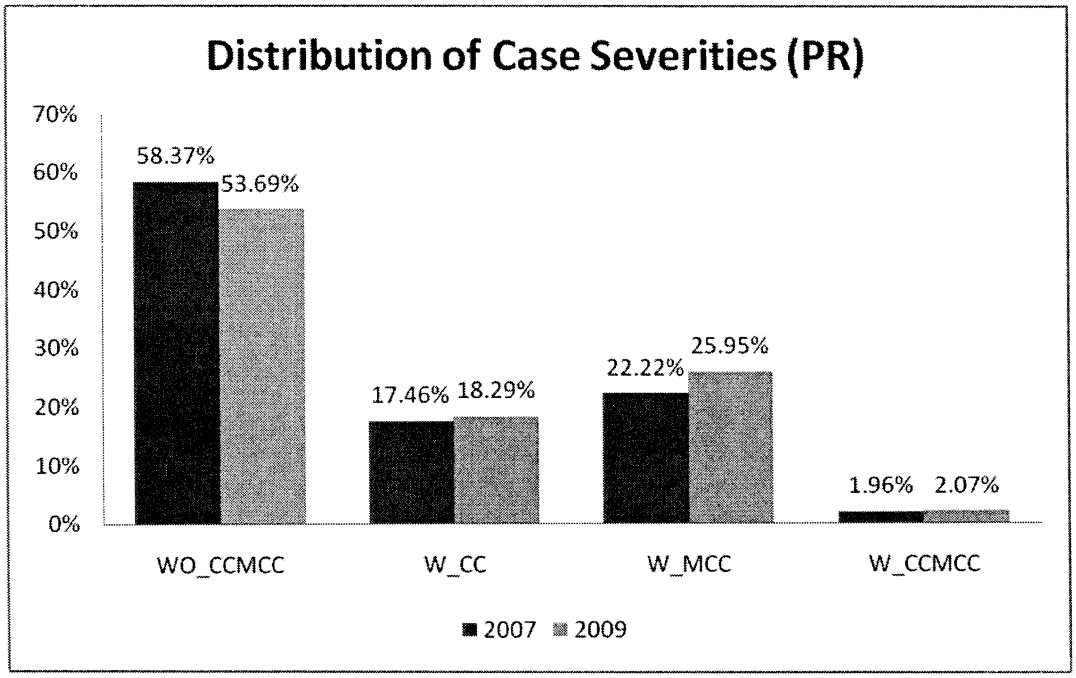
For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 claims data for Puerto Rico hospitals using the same methodology described earlier for IPPS hospitals paid under the national standardized amounts under section 1886(d) of the Act. We found that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent. When we calculated the within-base DRG changes and the across-base DRG changes for Puerto Rico hospitals, we found that responsibility for the case-mix change between FY 2007 and FY 2008 is much more evenly shared. Across-base DRG shifts accounted for 44 percent of the changes, and within-base DRG shifts accounted for 56 percent. Thus, the change in the percentage of discharges with an MCC was not as large as that for other IPPS hospitals. In Figure 4 in the FY 2010 proposed rule, we showed that, for Puerto Rico hospitals, there was a 3 percentage point increase in the discharges with an MCC from 22 percent to 25 percent and a corresponding decrease of 3 percentage points from 58 percent to 55 percent in discharges without a CC or an MCC.

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

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43777), we indicated that, given these documentation and coding increases, consistent with our statements in prior IPPS rules, we would use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific rate. However, in parallel to our decision to postpone adjustments to the Federal standardized amount, we indicated that we were adopting a similar policy for the Puerto Rico-specific rate for FY 2010 and would consider the phase-in of this adjustment over an appropriate time period through future rulemaking. The adjustment would be applied to the Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount. Consequently, the overall reduction to the payment rates for Puerto Rico hospitals to account for documentation and coding changes will be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national standardized amount. We noted that, as with the hospital-specific rates, the Puerto Rico-specific standardized amount had not previously been reduced based on estimated changes in documentation and coding associated with the adoption of the MS–DRGs. However, as we note earlier for IPPS hospitals and hospitals receiving hospital-specific rates, if the estimated documentation and coding effect are determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for the FY 2008 and FY 2009 combined adjustment. Therefore, we believed that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data for Puerto Rico hospitals.

Consistent with our approach for IPPS hospitals for FY 2010, we indicated that we would address in the FY 2011 rulemaking cycle any change in FY 2009 case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. We noted that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

As we have noted above, similar to SCHs and MDHs, hospitals in Puerto Rico use the same MS–DRG system as all other hospitals and we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to the prospective budget neutrality adjustment that we intend to apply to prospective payment rates for IPPS hospitals including SCHs and MDHs in order to eliminate the full effect of the documentation and coding changes associated with implementation of the MS–DRG system.



In the above chart, consistent with our findings for IPPS hospitals, for Puerto Rico hospitals, there is a 4 percentage point increase in the discharge severity with MCCs from 22 percent to 26 percent, and a corresponding decrease of 4 percentage points in discharge severity without CC/MCC from 58 percent to 54 percent.

Using the same methodology we applied to estimate documentation and coding changes under IPPS for non-Puerto Rico hospitals, as we have also discussed above, our best estimate, based on the most recently available data, is that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to Puerto Rico hospitals to account for documentation and coding changes. Therefore, the entire −2.4 percent adjustment remains to be implemented.

As we stated above, we believe it important to maintain both consistency and equity among all hospitals paid on the basis of the same MS–DRG system. At the same time, however, we recognize that the estimated cumulative impact on aggregate payment rates resulting from implementation of the MD–DRG system was smaller for Puerto Rico hospitals as compared to IPPS hospitals and SCHs and MDHs. We therefore are proposing an adjustment of −2.4 percent in FY 2011 to Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount, which we are proposing to adjust as described above. Consequently, the overall reduction to rates for Puerto Rico hospitals to account for the documentation and coding changes will be slightly less than the reduction for IPPS hospitals based on 100 percent of the national standardized amount. We note that this proposed −2.4 percent prospective adjustment would eliminate the full effect of the documentation and coding changes on the portion of future payments to Puerto Rico hospitals based on the Puerto Rico-specific rate. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity as much as possible between hospitals paid on the basis of different prospective rates. One reason for proposing the full −2.4 percent adjustment for the Puerto Rico-specific rate in FY 2011 is to maintain equity as much as possible in the documentation and coding adjustments applied to various hospital rates in FY 2011. Because this proposed −2.4 percent adjustment represents the full adjustment that is warranted for the Puerto Rico-specific rate, we do not anticipate proposing any additional adjustments to the rate for documentation and coding effects.

We are seeking public comment on the proposed −2.4 percent prospective adjustment to Puerto Rico-specific standardized amount under section 1886(d)(5)(I)(i) of the Act. We intend to update our analysis with FY 2009 data on claim paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

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

transition blend from charge-based relative weights to cost-based relative weights (71 FR 47882 through 47898).)

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

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

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

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

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

RTI's final report found that, under the IPPS and the OPPS, accounting improvements to the cost reporting data reduce some of the sources of aggregation bias without having to use regression-based adjustments. In general, with respect to the regression-based adjustments, RTI confirmed the findings of its March 2007 report that regression models are a valid approach for diagnosing potential aggregation bias within selected services for the IPPS and found that regression models are equally valid for setting payments under the OPPS.

RTI also noted that cost-based weights are only one component of a final prospective payment rate. There are other rate adjustments (wage index, IME, and DSH) to payments derived from the revised cost-based weights, and the cumulative effect of these components may not improve the ability of final payment to reflect resource cost. RTI endorsed short-term regression-based adjustments, but also concluded that more refined and accurate accounting data are the preferred long-term solution to mitigate charge compression and related bias in hospital cost-based weights. For a more detailed summary of RTI's findings, recommendations, and public comments we received on the report, we refer readers to the FY 2009 IPPS final rule (73 FR 48452 through 48453).

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

One of the reasons that we did not implement regression-based CCRs at the time of the FY 2008 IPPS final rule with comment period was our inability to investigate how regression-based CCRs would interact with the implementation of MS–DRGs. In the FY 2008 final rule with comment period (72 FR 47197), we stated that we engaged the RAND Corporation as the contractor to evaluate the HSRV methodology in conjunction with regression-based CCRs, and that we would consider its analysis as we prepared for the FY 2009 IPPS rulemaking process.

RAND evaluated six different methods that could be used to establish relative weights; CMS' current relative weight methodology of 15 national CCRs and 5 alternatives, including a method in which the 15 national CCRs are disaggregated using the regression-based methodology, and a method using hospital-specific CCRs for the 15 cost center groupings. In addition, RAND analyzed our standardization methodologies that account for systematic cost differences across hospitals. The purpose of standardization is to eliminate systematic facility-specific differences in cost so that these cost differences do not influence the relative weights. Overall, RAND found that none of the methods it studied of calculating the relative weights represented a marked improvement in payment accuracy over the current method, and there was little difference across methods in their ability to predict cost at either the discharge-level or the hospital-level. In their regression analysis, RAND found

that, after controlling for hospital payment factors, the relative weights are compressed (that is, understated). However, RAND also found that the hospital payment factors are overstated and increase more rapidly than cost. Therefore, while the relative weights are compressed, these payment factors offset the compression such that total payments to hospitals increase more rapidly than hospitals' costs.

In the FY 2009 IPPS final rule (73 FR 48453 through 48457), we provided a summary of the RAND report and the public comments we received in response to the FY 2009 IPPS proposed rule. The report may be found on RAND's Web site at: *http://www.rand.org/pubs/working_papers/WR560/.*

2. Proposals for FY 2011 and Timeline for Changes to the Medicare Cost Report

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

When we developed the FY 2009 IPPS final rule, we considered all of the public comments we received both for and against adopting regression-based CCRs. Also noteworthy is RAND's belief that regression-based CCRs may not significantly improve payment accuracy, and that it is equally, if not more, important to consider revisions to the current IPPS hospital payment factor standardization method in order to improve payment accuracy. For FY 2010, we solicited comments on improving the standardization process, although we did not make any changes to the standardization process for FY 2010. We also stated that we continued to believe that, ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of the cost weights. Accordingly, a new subscripted line 55.01 for Implantable Devices Charged to Patients was created in July 2009 as part of CMS' Transmittal 20 update to the existing cost report Form CMS–2552–96. This new subscripted cost center is available for use for cost reporting periods beginning on or after May 1, 2009.

With respect to the initiative to reform, update, and streamline the Medicare cost report, which has been the subject of many comments and our responses in the IPPS (and OPPS) **Federal Register** notices of rulemaking over the past several years, CMS is continuing to work on this project. The new draft hospital cost report Form CMS–2552–10 was published in the **Federal Register** on July 2, 2009, and was subject to a 60-day review and comment period, which ended August 31, 2009. CMS received numerous comments on the draft hospital cost report Form CMS–2552–10, specifically regarding the creation of new cost centers from which data would be ultimately used in the relative weights calculation, even though CMS had not proposed to add these cost centers. The public comments on the July 2, 2009 **Federal Register** notice will be addressed in detail in the **Federal Register** notice that will be issued to finalize Form CMS–2525–10. We now plan to issue the revised draft of the hospital cost report Form CMS–2552–10, which will include a standard cost center for Implantable Devices Charged to Patients, through a notice in the **Federal Register**, which will allow for a 30-day comment period, in the spring or summer of 2010. However, in part in this IPPS proposed rule, we are providing a summary of the public comments received on the July 2, 2009 notice that specifically related to the relative weights and responding to those comments. Our responses to the comments in this IPPS proposed rule constitute our proposals for FY 2011 regarding the relative weights.

Several commenters asked that CMS create cost centers to house the costs of magnetic resonance imaging (MRI), Computed Tomography (CT), nuclear medicine services, cardiac catheterization, drugs that require detailed coding, and magnetoencephalography (MEG). One commenter indicated, that in RTI's July 2008 report (*http://www.rti.org/reports/cms/*), RTI made an argument that CMS should create new standard cost centers in which hospitals would report the costs of MRI scans, CT scans, cardiac catheterization, and drugs that require detailed coding, in addition to the new cost center for "Implantable Devices Charged to Patients." The commenter stated that these additional lines are needed to distinguish items and services that hospitals tend to markup differently within existing revenue centers, citing RTI's finding that CT scans have a significantly higher markup than most other radiology services. The commenter indicated that when CMS uses the overall radiology department CCR to convert charges for CT scans to costs, it overestimates the cost of these services, resulting in overstated relative weights for MS–DRGs under the IPPS and for APCs under the OPPS that incorporate CT scanning. The commenter argued that having a separate cost center for each of these services would resolve the problem. The commenter also stated that, while CMS has done something similar with the creation of the cost center for high cost medical devices, making cost center changes for some services, but not others, where such changes are warranted could create additional distortion in the relative weights. The commenter further argued that cost center changes should be made for all service areas with significant volume where services with sizable differences in markup are currently combined in a single cost center. The commenter asserted that creating these cost centers should not create reporting burden for hospitals because the RTI report indicated that roughly one-third of the hospitals are already reporting costs for CT scans, MRI scans, and cardiac catheterization under the specific nonstandard cost centers currently available in the cost report.

Another commenter also recommended the creation of the cost centers for CT scans, MRI scans, and nuclear medicine services, but for different reasons than the first commenter. Specifically, this commenter believed these new cost centers are necessary in order for the high capital costs to be appropriately allocated to these services and to be correctly reflected in the CCRs that are used in the establishment of the MS–DRG and APC payment rates for the services. The commenter stated that, under the existing cost report structure, some providers are allocating high capital costs for these services in a

single radiology line, diluting the high capital costs associated with CT scans, MRI scans, and nuclear medicine services across all radiology services, including low cost services. Therefore, the commenter concluded that the resulting radiology CCRs that CMS applies to charges for CT scans, MRI scans, and nuclear medicine services to arrive at the relative costs used to set payment rates for both the IPPS and OPPS understate the cost of high cost radiology services and overstate the cost of low cost radiology services, resulting in payments that are too low for the high cost services. The commenter indicated that CMS should not only create these new costs centers but should also require all hospitals to use them, and should issue explicit instructions on how to report the costs of these services in the new standard cost centers.

We agree that it is appropriate to create standard cost centers for CT scans, MRI scans, and cardiac catheterization and to require that hospitals report the costs and charges for these services under new cost centers on the revised Medicare cost report Form CMS 2552–10. As we discussed in the FY 2009 IPPS and CY 2009 OPPS proposed and final rules, RTI found that the costs and charges of CT scans, MRI scans, and cardiac catheterization differ significantly from the costs and charges of other services included in the standard associated cost center. RTI also concluded that both the IPPS and OPPS relative weights would better estimate the costs of those services if CMS were to add standard costs centers for CT scanning, MRIs, and cardiac catheterization in order for hospitals to report separately the costs and charges for those services and in order for CMS to calculate unique CCRs to estimate the cost from charges on claims data.

In its analysis, RTI concluded that the estimated costs for CT scanning and MRI scans would decline significantly and that the estimated cost for cardiac catheterization would increase modestly if specific standard cost centers were used. RTI found that cardiac catheterization has very different cost inputs from most cardiac testing (for example, electrocardiograms or cardiac stress testing) captured in the 5300 "Electrocardiology" cost center and that the accuracy of the CCR for both types of services, cardiac catheterization and other cardiac testing, would improve with creation of a standard cost center for cardiac catheterization. RTI also found that one-third of hospitals already report cardiac catheterization costs and charges separately through the available nonstandard cost center or through subscripted lines to the "Electrocardiology" cost center. Similarly, RTI found that approximately one-third of hospitals already separately report the costs for CT scanning and MRI scans on their Medicare cost report through subscripted lines and the available nonstandard cost centers. We believe the current prevalence of reporting for the nonstandard cost centers for these three services suggests a modest hospital burden required to adopt these cost centers.

We discussed the possibility of creating standard cost centers for these three different services in our CY 2009 OPPS proposed and final rule with comment period (73 FR 41432 and 73 FR 68525) and solicited general comments on RTI's recommendations. The commenters who objected to the creation of the standard cost centers for CT scanning and MRI scans largely did so based on RTI projected lower estimated costs for these services if CMS created these cost centers. The commenters suggested that the current CCRs for advanced imaging may reflect a misallocation of capital costs and requested that CMS not adopt separate cost centers or statistical adjustment simulating lower CCRs for CT scanning and MRI until CMS could understand how providers are allocating the extensive capital costs for these services to the revenue producing cost centers. We also received comments suggesting that the accuracy of estimated costs would improve with better allocation, potentially increasing the CCR as more capital cost would be appropriately allocated to both CT scanning and MRI and not spread across all services in the radiology cost center. We noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68525) that our recommended allocation of moveable equipment costs in Worksheet A of the Medicare cost report is based on dollar value, and that it would be important to encourage improved accuracy of capital allocation through dollar value or direct assignment if we were to make these cost centers standard cost centers. At this time, we do not know the impact on CCRs and estimated costs of adopting standard cost centers specific to CT scanning and MRI. However, we believe that, because these areas constitute significant payment under both the IPPS and OPPS and because these are common imaging services already widely reported by hospitals, we are proposing to adopt new standard cost centers for CT scanning and MRI. We agree with those commenters who asserted that creation of standard cost centers for CT scanning and MRI would improve the accuracy of cost estimation for these services, in part by creating incentives for hospitals to more accurately allocate the capital and equipment associated with these services.

With regard to cardiac catheterization, we received one comment on the CY 2009 OPPS/ASC proposed rule suggesting that hospitals might find it difficult to allocate costs for these services to specific cost centers, especially for cardiac catheterization, and that allocated overhead costs would, in most cases, be an estimate (73 FR 68527). However, given the number of hospitals already reporting the nonstandard cost center for cardiac catheterization and the number subscripting these costs and charges (approximately 50 percent, according to RTI's July 2008 report (pages 71 and 72) at: *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*), we believe that hospitals do allocate overhead costs to a cardiac catheterization-specific cost center. For these reasons, we are proposing to create standard cost centers for CT scanning, MRI, and cardiac catheterization in Form CMS 2552–10.

We also received public comments on the cost report notice urging us to create standard cost centers for nuclear medicine services, for drugs that require detailed coding, and for MEG. We continue to believe that it is not appropriate to create standard cost centers for these three services. The Medicare cost report already contains standard cost center 4300 (Radioisotope) to capture the costs and charges for the radioisotopes used in nuclear medicine services, the items that may have significantly different costs and hospital markup than the supplies and equipment used in other radiology services. Moreover, the cost report already contains standard cost center 4100 (Diagnostic Radiology) in which the costs of staff, equipment, and supplies for diagnostic nuclear medicine services can be reported. Therefore, we continue to believe that creating a new standard cost center for nuclear medicine services is not necessary. We also continue to believe that it is not appropriate to create a standard cost center for drugs that require detailed coding. We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68655) for a detailed discussion on our final decision not to create this cost center. Finally, with respect to MEG services, the extremely low volume of

claims for MEG services furnished to Medicare beneficiaries in the hospital outpatient setting and the extremely low number of hospitals that report these codes relative to the volumes we typically have considered in adding both standard and nonstandard cost centers to the cost report lead us to conclude that a specific cost center for MEG is not justified at this time.

There is typically a 3-year lag between the availability of the cost report data that we use to calculate the relative weights both under the IPPS and the OPPS and a given fiscal or calendar year. We expect the data from the proposed standard cost centers for CT scans, MRI, and cardiac catheterization respectively, should they be finalized, to be available for possible use in calculating the relative weights not earlier than 3 years after Form CMS–2552–10 becomes available. At that time, we would analyze the data and determine if it is appropriate to use those data to create distinct CCRs from these cost centers for use in the relative weights for the respective payment systems. If we decide to finalize these proposed new cost centers, the upcoming **Federal Register** notice that will finalize Form CMS–2552–10 will provide more information regarding the addition of these proposed new standard cost centers for CT scans, MRI, and cardiac catheterization, including the instructions for completing these cost centers on the new cost report.

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

1. Background

a. Statutory Authority

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

Section 1886(d)(4)(D)(iii) of the Act requires that hospitals, effective with discharges occurring on or after October 1, 2007, submit information on Medicare claims specifying whether diagnoses were present on admission (POA). Section 1886(d)(4)(D)(i) of the Act specifies that effective for discharges occurring on or after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS–DRG if a selected condition is not POA. Thus, if a selected condition that was not POA manifests during the hospital stay, it is considered a HAC and the case is paid as though the secondary diagnosis was not present. However, even if a HAC manifests during the hospital stay, if any nonselected CC/MCC appears on the claim, the claim will be paid at the higher MS–DRG rate. Under the HAC payment policy, all CCs/MCCs on the claim must be HACs in order to generate a lower MS–DRG payment. In addition, Medicare continues to assign a discharge to a higher paying MS–DRG if a selected condition is POA.

The POA indicator reporting requirement and the HAC payment provision apply to IPPS hospitals only. Non-IPPS hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's hospitals, hospitals in Maryland operating under waivers, rural health clinics, federally qualified health centers, RNHCIs, and Department of Veterans Affairs/Department of Defense hospitals, are exempt from POA reporting and the HAC payment provision. Throughout this section, the term "hospital" refers to an IPPS hospital.

The HAC provision found in section 1886(d)(4)(D) of the Act is part of an array of Medicare value-based purchasing (VBP) tools that we are using to promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through Quality Improvement Organization (QIO) activities. The application of VBP tools, such as this HAC provision, is transforming Medicare from a passive payer to an active purchaser of higher value health care services. We are applying these strategies for inpatient hospital care and across the continuum of care for Medicare beneficiaries.

These VBP tools are highly compatible with the underlying purposes as well as existing structural features of Medicare's IPPS. Under the IPPS, hospitals are encouraged to treat patients efficiently because they receive the same DRG payment for stays that vary in length and in the services provided, which gives hospitals an incentive to avoid unnecessary costs in the delivery of care. In some cases, conditions acquired in the hospital do not generate higher payments than the hospital would otherwise receive for cases without these conditions. To this extent, the IPPS encourages hospitals to avoid complications.

However, the treatment of certain conditions can generate higher Medicare payments in two ways. First, if a hospital incurs exceptionally high costs treating a patient, the hospital stay may generate an outlier payment. Because the outlier payment methodology requires that hospitals experience large losses on outlier cases before outlier payments are made, hospitals have an incentive to prevent outliers. Second, under the MS–DRGs system that took effect in FY 2008 and that has been refined through rulemaking in subsequent years, certain conditions can generate higher payments even if the outlier payment requirements are not met. Under the MS–DRG system, there are currently 258 sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or an MCC. The presence of a CC or MCC generally results in a higher payment. However, since we implemented the HAC provisions, if a secondary diagnosis acquired during a hospital stay is a HAC and no other CCs or MCCs are present, the hospital receives a payment under the MS–DRGs as if the HACs were not present. (We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a discussion of DRG reforms (72 FR 47141).)

b. HAC Selection

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

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

In the FY 2009 IPPS proposed rule (73 FR 23547), we proposed several additional candidate HACs as well as refinements to the previously selected HACs. In the FY 2009 IPPS final rule (73 FR 48471), we expanded and refined

several of the previously selected HACs, and we selected 2 additional categories of HACs.

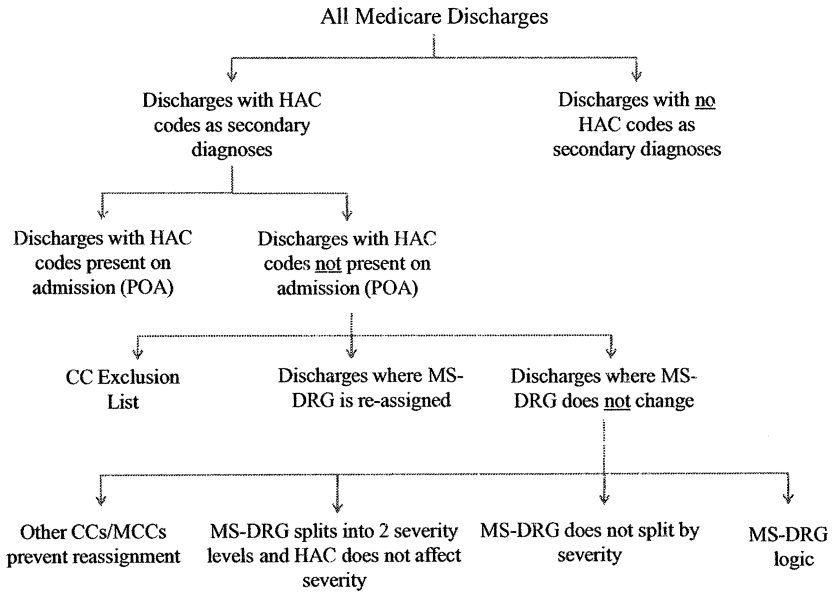
In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106), we proposed the addition of ICD–9–CM codes 813.46 (Torus fracture of ulna) and 813.47 (Torus fracture of radius and ulna) to more precisely define the previously selected HAC category of Falls and Trauma. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43784), we finalized the addition of these codes. A complete list of the 10 current categories of HACs is included in section II.F.2. of this preamble.

c. Collaborative Process

In establishing the HAC payment policy under section 1886(d)(4)(D) of the Act, our experts have worked closely with public health and infectious disease professionals from across the Department of Health and Human Services, including CDC, the Agency for Healthcare Research and Quality (AHRQ), and the Office of Public Health and Science (OPHS), to identify the candidate preventable HACs, review comments, and select HACs. CMS and CDC have also collaborated on the process for hospitals to submit a POA indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications of the various POA reporting options. As discussed below, we have also used rulemaking and Listening Sessions to receive public input.

d Application of HAC Payment Policy to MS–DRG Classifications

As described above, in certain cases application of the HAC payment policy provisions can result in MS–DRG reassignment to a lower paying MS–DRG. The following diagram portrays the logic of the HAC payment policy provision as adopted in the FY 2008 IPPS final rule (72 FR 47200) and in the FY 2009 IPPS final rule (73 FR 48471):



e. Public Input Regarding Selected and Potential Candidate HACs

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

In response to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106), commenters expressed strong support for a program evaluation prior to modifying the HAC list. We responded to these commenters and expressed our appreciation for the public's support for our decision to undertake a program evaluation. We indicated that we planned to include updates and findings from the evaluation on CMS' Hospital-Acquired Conditions and Present on Admission Indicator Web site available at: *http://www.cms.hhs.gov/HospitalAcqCond/*. We also responded to commenters regarding POA indicator reporting as well as to comments addressing other topics related to HACs and POA reporting (74 FR 43785).

f. POA Indicator Reporting

Collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision as well as for broader public health uses of Medicare data. Through Change Request No. 5679 (released on June 20, 2007), we issued instructions requiring IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims. We also issued Change Request No. 6086 (released on June 13, 2008) regarding instructions for processing non-IPPS claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the *ICD–9–CM Official Guidelines for Coding and Reporting,* available on the CDC Web site at: *http://www.cdc.gov/nchs/data/icd9/icdguide09.pdf.* Additional information regarding POA indicator reporting and application of the POA reporting

options is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalAcqCond.* Historically we have not provided coding advice. Rather, we collaborate with the American Hospital Association (AHA) through the *Coding Clinic for ICD–9–CM.* We have been collaborating with the AHA to promote the *Coding Clinic for ICD–9–CM* as the source for coding advice about the POA indicator.

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

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

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

Beginning on or after January 1, 2011, hospitals will begin reporting with the 5010 format. The 5010 format removes the need to report a POA indicator of "1" for codes that are exempt from POA reporting. The POA indicator of "1" is being used because of reporting restrictions from the use of the 4010 format. Therefore, hospitals that begin reporting with the 5010 format on and after January 1, 2011, will no longer report a POA indicator of "1" for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting. We are planning to issue CMS instructions on this reporting change.

2. Proposed HAC Conditions for FY 2011

As changes to diagnosis codes and new diagnosis codes are proposed and finalized for the list of CCs and MCCs, we will modify the list of selected HACs to reflect these changes. In Table 6A in the Addendum to this proposed rule, we have listed the proposed addition of five new ICD–9–CM diagnosis codes to replace existing ICD–9–CM code 999.6 (ABO incompatibility reaction) for FY 2011. ICD–9–CM code 999.6 is currently the only code identified under the Blood Incompatibility HAC category. We are proposing to delete code 999.6 and form a new subcategory of 999.6 to identify new diagnoses relating to ABO incompatibility reaction due to transfusion of blood or blood products. These diagnoses meet the criteria for the Blood Incompatibility HAC category based on the predecessor code 999.6 being a selected HAC.

As shown in Table 6C in the Addendum to this proposed rule, we are proposing that code 999.6 become invalid as a diagnosis code in FY 2011 with the creation of this new ICD–9–CM subcategory. This proposed new subcategory would allow room for expansion and the creation of the following new diagnosis codes:

ICD–9–CM code	Code descriptor	Proposed CC/MCC designation
999.60	ABO incompatibility reaction, unspecified	CC
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC
999.62	ABO incompatibility with acute hemolytic transfusion reaction	CC
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	CC
999.69	Other ABO incompatibility reaction	CC

We are inviting public comments on the proposed adoption of the five ICD–9–CM diagnosis codes as CCs that are listed above, which, if finalized, would be added to the current HAC Blood Incompatibility category.

The following table lists the current HACs categories and the ICD–9–CM codes that identify the conditions that have been finalized through FY 2010. For FY 2011, we are proposing that these conditions continue to be subject to the HAC payment provision, with a proposed refinement to the codes to identify blood incompatibility as described above.

HAC	CC/MCC (ICD–9–CM code)
Foreign Object Retained After Surgery	998.4 (CC)
	998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC)
	707.24 (MCC)
Falls and Trauma	Codes within these ranges on the CC/MCC list:
—Fracture	800–829
—Dislocation	830–839
—Intracranial Injury	850–854

HAC	CC/MCC (ICD–9–CM code)
—Crushing Injury	925–929
—Burn	940–949
—Electric Shock	991–994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10–250.13 (MCC) 250.20–250.23 (MCC) 251.0 (CC) 249.10–249.11 (MCC) 249.20–249.21 (MCC)
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01–81.08, 81.23–81.24, 81.31–81.38, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis*—278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40–453.42 (CC) And one of the following procedure codes: 00.85–00.87, 81.51–81.52, or 81.54

We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) and to section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48486) for detailed analyses supporting the selection of each of these HACs. We invite public comments on our proposal that these conditions continue to be subject to the HAC payment provision, with a proposed refinement of the codes to identify blood incompatibility as described above.

3. RTI Program Evaluation Summary

a. Background

On September 30, 2009, a contract was awarded to Research Triangle Incorporated (RTI) to evaluate the impact of the Hospital-Acquired Condition-Present on Admission (HAC–POA) provisions on the changes in the incidence of selected conditions, effects on Medicare payments, impacts on coding accuracy, unintended consequences, and infection and event rates. This is an intra-agency project with funding and technical support coming from CMS, OPHS, AHRQ, and CDC. The evaluation will also examine the implementation of the program and evaluate additional conditions for future selection.

RTI's evaluation of the HAC–POA provisions is divided into several parts, only some of which will be complete prior to the publication date of this proposed rule. Below we summarize the analyses that are complete. RTI's analyses of POA indicator reporting, frequencies and net savings associated with current HACs, and frequencies of previously considered candidate HACs reflect MedPAR claims from October 2008 through June 2009. In the final rule, we intend to update our summary of these analyses with additional data that have become available.

b. Preliminary RTI Analysis on POA Indicator Reporting Across Medicare Discharges

To better understand the impact of HACs on the Medicare program, it is necessary to first examine the incidence of POA indicator reporting across all eligible Medicare discharges. As mentioned previously, only IPPS hospitals are required to submit POA indicator data for all diagnosis codes on Medicare claims. Therefore, all non-IPPS hospitals were excluded, as well as providers in waiver States (Maryland) and territories other than Puerto Rico.

Using MedPAR claims data from October 2008 through June 2009, RTI found a total of approximately 50.22 million secondary diagnoses across approximately 7.17 million discharges. As shown in Chart A below, the majority of all secondary diagnoses (83.52 percent) were reported with a POA indicator of "Y," meaning the condition was POA.

CHART A—POA CODE DISTRIBUTION ACROSS ALL SECONDARY DIAGNOSES

	Number	Percentage
Total Discharges in Final File	7,175,139	
Total Number of Secondary Diagnoses Across Total Discharges	50,216,195	100.00

POA	Indicator Description		
Y	Condition present on admission	41,938,234	83.52
W	Status cannot be clinically determined	12,547	0.02
N	Condition not present on admission	3,440,815	6.85
U	Documentation not adequate to determine if condition was present on admission.	110,771	0.22
1	Exempted ICD–9–CM code	4,713,828	9.39

Source: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

c. Preliminary RTI Analysis on POA Indicator Reporting of Current HACs

Following the initial analysis of POA indicator reporting for all secondary diagnoses, RTI then evaluated POA indicator reporting for specific HAC-associated secondary diagnoses. The term "HAC-associated secondary diagnosis" refers to those diagnoses that are on the selected HAC list and were reported as a secondary diagnosis. Chart B below shows a summary of the HAC categories with the frequency in which each HAC was reported as a secondary diagnosis and the corresponding POA indicators assigned on the claims. It is important to note that, because more than one HAC-associated diagnosis code can be reported per discharge (that is, on a single claim), the frequency of HAC-associated diagnosis codes may be more than the actual number of discharges that have a HAC-associated diagnosis code reported as a secondary diagnosis. Below we discuss the frequency of each HAC-associated diagnosis code and the POA indicators assigned to those claims.

RTI analyzed the frequency of each reported HAC-associated secondary diagnosis (across all 7.17 million discharges) and the POA indicator assigned to the claim. Chart B below shows that the most frequently reported conditions were in the Falls and Trauma HAC category, with a total of 132,666 HAC-associated diagnosis codes being reported for that HAC category. Of these 132,666 diagnoses, 4,081 reported a POA indicator of "N" for not POA and 128,286 diagnoses reported a POA indicator of "Y" for POA. The lowest frequency appears in the Surgical Site Infection (SSI) Following Bariatric Surgery for Obesity HAC category with only 12 HAC-associated secondary diagnosis codes (and procedure codes) reported.

CHART B—POA STATUS OF CURRENT HACS: OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA = N		POA = U		POA = Y		POA = W	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Foreign Object Retained After Surgery (CC)	378	172	45.5	0	0.0	206	54.5	0	0.0
2. Air Embolism (MCC)	29	23	79.3	0	0.0	6	20.7	0	0.0
3. Blood Incompatibility (CC)	23	8	34.8	0	0.0	15	65.2	0	0.0
4. Pressure Ulcer Stages III & IV (MCC)	80,190	944	1.2	56	0.1	79,165	98.7	25	0.0
5. Falls and Trauma (MCC & CC)	132,666	4,081	3.1	232	0.2	128,286	96.7	67	0.1
6. Catheter-Associated UTI (CC)	11,424	1,887	16.5	15	0.1	9,496	83.1	26	0.2
7. Vascular Catheter-Associated Infection (CC)	5,470	2,091	38.2	19	0.3	3,348	61.2	12	0.2
8. Poor Glycemic Control (MCC)	11,070	344	3.1	9	0.1	10,711	96.8	6	0.1
9A. Surgical Site Infection Mediastinitis CABG (CC)	29	21	72.4	0	0.0	8	27.6	0	0.0
9B. Surgical Site Infection Following Bariatric Surgery for Obesity (CC)	12	10	83.3	0	0.0	2	16.7	0	0.0
9B. Surgical Site Infection Following Certain Orthopedic Procedures (CC)	202	125	61.9	1	0.5	75	37.1	1	0.5
10. Pulmonary Embolism & DVT Orthopedic (MCC)	2,706	2,029	75.0	15	0.6	647	23.9	15	0.6
Total *	244,199			347				152	

* Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these discharges resulted in MS–DRG reassignment).

We welcome public comments on these data that can provide insight into the accuracy of the data, using comparative data sets or analysis such as how aspects of the coding system might influence these data.

As described earlier, in the FY 2009 IPPS final rule (73 FR 48486 through 48487), we adopted as final our proposal to: (1) Pay the CC/MCC MS–DRGs for those HACs coded with "Y" and "W" indicators; and (2) not pay the CC/MCC MS–DRGs for those HACs coded with "N" and "U" indicators. We also discussed the comments we received urging CMS to strongly consider changing the policy and to pay for those HACs assigned a POA indicator of "U" (documentation is insufficient to determine if the condition was present at the time of admission). We stated we would monitor the extent to which and under what circumstances the "U" POA reporting option is used. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also discussed and responded to comments regarding HACs coded with the "U" indicator (74 FR 43784 and 43785). As shown in Chart B above, RTI's analysis provides some initial data on a total of 347 HAC-associated secondary diagnoses reported with a POA indicator of "U". Of those diagnoses, 232 (0.2 percent) were assigned to the Falls and Trauma HAC category.

We continue to believe that better documentation will result in more accurate public health data. Because the RTI analysis is based on preliminary data, at this time we are not proposing to change our policy under which CMS does not pay at the higher CC/MCC amount when a selected HAC diagnosis code is reported with a POA indicator of "U."

We encourage readers to further review the RTI detailed report which demonstrates the frequency of each individual HAC-associated diagnosis code within the HAC categories. For example, in the Foreign Object Retained After Surgery HAC category, there are two unique ICD–9–CM diagnosis codes to identify that condition: code 998.4 (Foreign body accidentally left during a procedure) and code 998.7 (Acute reaction to foreign substance accidentally left during a procedure). In the detailed RTI report, readers can view that code 998.4 was reported 368 times and code 998.7 was reported 10 times, for a total of 378 times, as shown in Chart B above. The RTI detailed report is available at the following Web site: *http://www.rti.org/reports/cms/*.

d. Preliminary RTI Analysis of Frequency of Discharges and POA Indicator Reporting for Current HACs

RTI further analyzed the effect of the HAC provision by studying the frequency in which a HAC-associated diagnosis was reported as a secondary diagnosis with a POA indicator of "N" or "U" and, of that number, how many resulted in MS–DRG reassignment. In Chart C below, Column A shows the number of discharges for each HAC category where the HAC-associated diagnosis was reported as a secondary diagnosis. For example, there were 29 discharges that reported Air Embolism as a secondary diagnosis. Column C shows the number of discharges for each HAC reported with a POA indicator of "N" or "U." Continuing with the example of Air Embolism, the chart shows that, of the 29 reported discharges, 23 discharges (79.31 percent) had a POA indicator of "N" or "U" and was identified as a HAC discharge. There were a total of 23 discharges to which the HAC policy applies and that could, therefore, have had an MS–DRG reassignment. Column E shows the number of discharges where an actual MS–DRG reassignment occurred. As shown in Column E, the number of discharges with an Air Embolism that resulted in actual MS–DRG reassignments is 12 (52.17 percent of the 23 discharges with a POA indicator of "N" or "U"). Thus, while there were 23 discharges (79.31 percent of the original 29) with an Air Embolism reported with a POA indicator of "N" or "U" identified as a HAC discharge that could have caused MS–DRG reassignment, the end result was 12 (52.17 percent) actual MS–DRG reassignments. There are a number of reasons why a selected HAC reported with a POA indicator of "N" or "U" will not result in MS–DRG reassignment. These reasons were illustrated with the diagram in section II.F.1.c. of this preamble and will be discussed in further detail in section II.F.3.e. of this preamble.

Chart C below also shows that, of the 216,764 discharges with a HAC-associated diagnosis as a secondary diagnosis, 3,038 discharges ultimately resulted in MS–DRG reassignment. As will be discussed below, there were 15 claims that resulted in MS–DRG reassignment where two HACs were reported on the same admission. The four HAC categories that had the most discharges resulting in MS–DRG reassignment were: (1) Falls and Trauma; (2) Pressure Ulcer Stages III & IV; (3) Pulmonary Embolism and DVT Orthopedic (Orthopedic PE/DVT); and (4) Catheter-Associated Urinary Tract Infection (UTI). Codes falling under the Falls and Trauma HAC category were the most frequently reported secondary diagnoses with 109,728 discharges. Of these 109,728 discharges, 3,852 (3.51 percent) were coded as not POA and identified as HAC discharges. This category also contained the greatest number of discharges that resulted in an MS–DRG reassignment. Of the 3,852 discharges within this HAC category that were not POA, 1,476 (38.32 percent) resulted in an MS–DRG reassignment.

Of the 216,764 total discharges reporting HAC-associated diagnoses as a secondary diagnosis, 2,494 discharges were coded with a secondary diagnosis of Orthopedic PE/DVT. Of these 2,494 discharges, 1,892 (75.86 percent) were coded as not POA and identified as HAC discharges. This category contained the second greatest number of discharges resulting in an MS–DRG reassignment. Of the 1,892 discharges in this HAC category that were not POA, 845 discharges (44.66 percent) resulted in an MS–DRG reassignment.

The Pressure Ulcer Stages III & IV category had the second most frequently coded secondary diagnoses, with 76,014 discharges. Of these discharges, 960 (1.26 percent) were coded as not POA and identified as HAC discharges. This category contained the third greatest number of discharges resulting in an MS–DRG reassignment. Of the 960 discharges in this HAC category that were not POA, 337 discharges (35.10 percent) resulted in an MS–DRG reassignment.

The Catheter-Associated UTI category had the third most frequently coded secondary diagnoses, with 11,434 discharges. Of these discharges, 1,896 (16.60 percent) were coded as not POA and identified as HAC discharges. This category contained the fourth greatest number of discharges resulting in an MS–DRG reassignment. Of the 1,896 discharges in this HAC category that were not POA, 197 discharges (10.39 percent) resulted in a MS–DRG reassignment.

The remaining 6 HAC categories only had 183 discharges that ultimately resulted in MS–DRG reassignment. We note that, even in cases where a large number of HAC-associated secondary diagnoses were coded as not POA, this finding did not necessarily translate into a large number of discharges that resulted in MS–DRG reassignment. For example, only 23 of the 2,107 Vascular Catheter-Associated Infection secondary diagnoses that were coded as not POA and identified as HAC discharges resulted in a MS–DRG reassignment.

There were a total of 277 discharges with a HAC-associated secondary diagnosis reporting a POA indicator of "N" or "U" that were excluded from acting as a HAC discharge (subject to MS–DRG reassignment) due to the CC Exclusion List logic within the GROUPER. The CC Exclusion List identifies secondary diagnosis codes designated as a CC or MCC that are disregarded by the GROUPER logic when reported with certain principal diagnoses. For example, a claim with the principal diagnosis code of 250.83 (Diabetes with other specified manifestations, type 1 [juvenile type], uncontrolled) and a secondary diagnosis code of 250.13 (Diabetes with ketoacidosis, type 1, [juvenile type], uncontrolled) with a POA indicator of "N" would result in the HAC-associated secondary diagnosis code 250.13 being ignored as a CC. According to the CC Exclusion List, code 250.13 is excluded from acting as a CC when code 250.83 is the principal diagnosis. As a result, the HAC logic would not be applicable to that case. For a detailed discussion on the CC Exclusion List, we refer readers to section II.G.9. of this preamble.

Discharges where the HAC logic was not applicable due to the CC Exclusion List occurred among the following 4 HAC categories: Pressure Ulcer Stages III and IV (29 cases), Falls and Trauma (206 cases), Catheter-Associated UTI (6 cases), Vascular Catheter-Associated Infection (3 cases), and Manifestations of Poor Glycemic Control (33 cases). Further information regarding the specific number of cases that were excluded for each HAC-associated secondary diagnosis code within each of the above mentioned HAC categories is also available. We refer readers to the RTI detailed report at the following Web site: *http://www.rti.org/reports/cms/*.

In summary, Chart C below demonstrates that there were a total of 216,764 discharges with a reported HAC-associated secondary diagnosis. Of the total 216,764 discharges, 11,383 (5.25 percent) discharges were HACs reported with a POA indicator of "N" or "U" that were identified as a HAC discharge. Of these 11,383 discharges, the number of discharges resulting in MS–DRG reassignments was 3,038 (26.69 percent).

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CHART C.—DISCHARGE FREQUENCIES OF CURRENT CMS HACS OCTOBER 2008 THRUGH JUNE 2009

Selected HAC Category	Discharges With This Condition as Secondary Diagnosis		Discharges Identified as a HAC		Discharges That Change MS-DRG Due to HAC	
	Number (Column A)	Percent[2] (Column B)	Number (Column C)	Percent[3] (Column D)	Number (Column E)	Percent[4] (Column F)
1. Foreign Object Retained After Surgery	378	0.01%	172	45.50%	40	23.26%
2. Air Embolism	29	0.00%	23	79.31%	12	52.17%
3. Blood Incompatibility	23	0.00%	8	34.78%	0	0.00%
4. Pressure Ulcer Stages III & IV	76,041	1.06%	960	1.26%	337	35.10%
a. Stage III	42,659	0.59%	726	1.70%	286	39.39%
b. Stage IV	37,531	0.52%	245	0.65%	53	23.27%
5. Falls and Trauma	109,728	1.53%	3,852	3.51%	1,476	38.32%
a. Fracture	98,624	1.37%	3,343	3.39%	1,267	37.90%
b. Dislocation	763	0.01%	19	2.49%	3	15.79%
c. Intracranial Injury	10,469	0.15%	478	4.57%	213	44.56
d. Crushing Injury	32	0%	1	3.13%	0	0
e. Burn	1,663	0.02%	33	1.98%	6	18.18%
f. Electric Shock	466	0.01%	8	1.72%	1	12.50%
6. Catheter-Associated UTI	11,424	0.16%	1,896	16.60%	197	10.39%
7. Vascular Catheter-Associated Infection	5,470	0.08%	2,107	38.52%	23	1.09%
8. Poor Glycemic Control	10,937	0.15%	319	2.92%	98	30.72%
9a. SSI Mediastinitis CABG	29	0.04%	21	72.41%	5	23.81%

Selected HAC Category	Discharges With This Condition as Secondary Diagnosis		Discharges Identified as a HAC		Discharges That Change MS-DRG Due to HAC	
	Number (Column A)	Percent[2] (Column B)	Number (Column C)	Percent[3] (Column D)	Number (Column E)	Percent[4] (Column F)
9b. SSI Orthopedic	199	0.26%	123	61.81%	4	3.25%
9c. SSI Bariatric	12	0.11%	10	83.33%	1	10.00%
10. Pulmonary Embolism & DVT Orthopedic	2,494	0.84%	1,892	75.86%	845	44.66%
Total[1]	216,764		11,383	5.25%	3,038	26.69%

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
[2] Percent computed relative to total discharges "at risk" for MS-DRG reassignment. For HACs 1 – 8, this is 7,175,139. For HAC 9a, this is 73,184. For HAC 9b, this is 76,104. For HAC 9c, this is 10,445. For HAC 10, this is 296,405.
[3] Percent computed relative to discharges with condition as a secondary diagnosis.
[4] Percent computed relative to discharges with condition as a secondary diagnosis and identified as a HAC (that is, coded as not present on admission), as identified in the Column E.

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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An extremely small number of discharges had multiple HACs reported during the same stay. In reviewing the 7.17 million claims, RTI found 47 cases in which two HACs were reported on the same discharge. Chart D below summarizes these cases. There were eight cases in which a Falls and Trauma HAC was reported in addition to a Pressure Ulcer Stages III & IV HAC. Eighteen of the cases with two HACs involved Pressure Ulcer Stages III & IV and 15 cases involved Falls or Trauma. Other multiple HAC cases included 9 Catheter-Associated UTI cases and 5 Vascular Catheter-Associated Infection cases.

Some of these cases with multiple HACs reported had both HAC codes ignored in the MS–DRG assignment. Of these 47 claims, 32 did not receive higher payments based on the presence of one or both of these reported HACs and we describe these claims below in section II.F.3.f.(2) of this preamble. Depending on the MS–DRG to which the cases were originally assigned, ignoring the HAC codes would have led to a MS–DRG reassignment if there were no other MCCs or CCs reported, if the MS–DRG was subdivided into severity levels, and if the case were not already in the lowest severity level prior to ignoring the HAC codes.

CHART D—CLAIMS WITH MORE THAN ONE HAC SECONDARY DIAGNOSIS OCTOBER 2008 THROUGH JUNE 2009

HAC	4. Pressure ulcer stages III & IV—MCC	5. Falls and trauma—MCC & CC	6. Catheter-associated UTI—CC	7. Vascular catheter-associated infection—CC
2. Air embolism—MCC		1		
5. Falls and Trauma—MCC & CC	8			
6. Catheter-Associated UTI—CC	2	3		
7. Vascular Catheter-Associated Infection—CC	5	4	6	
8. Poor Glycemic Control—MCC	1			1
9C. Surgical Site Infection Following Bariatric Surgery for Obesity—CC			2	1
10. Pulmonary Embolism & DVT Orthopedic—MCC	2	7	1	3
Total	18	15	9	5

e. Preliminary RTI Analysis of Circumstances When Application of HAC Provisions Would Not Result in MS–DRG Reassignment for Current HACs

As discussed in section II.F.1. and illustrated in the diagram in section II.F.1.c. of this preamble, there are instances when the MS–DRG assignment does not change even when a HAC-associated secondary diagnosis has a POA indicator of either "N" or "U." In analyzing our claims data, RTI identified four main reasons why a MS–DRG assignment would not change despite the presence of a HAC. Those four reasons are described below and are shown in Chart E below. Column A shows the frequency of discharges that included a HAC-associated secondary diagnosis. Column B shows the frequency of discharges where the HAC-associated secondary diagnosis was

coded as not POA and identified as a HAC discharge. Column C shows the frequency of discharges in which the HAC-associated secondary diagnosis coded as not POA resulted in a change in MS–DRG. Columns D, E, F, and G show the frequency of discharges in which the HAC-associated secondary diagnosis coded as not POA did not result in a change in MS–DRG assignment. Columns D, E, F, and G are explained in more detail below.

(1) Other MCCs/CCs Prevent Reassignment

Column D (Other MCC/CCs that Prevent Reassignment) in Chart E below indicates the number of cases reporting a HAC-associated secondary diagnosis code that did not have a MS–DRG reassignment because of the presence of other secondary diagnoses on the MCC or CC list. A claim that is coded with a HAC-associated secondary diagnoses and a POA status of either "N" or "U" may have other secondary diagnoses that are classified as an MCC or a CC. In such cases, the presence of these other MCC and CC diagnoses will still lead to the assignment of a higher severity level, despite the fact that the GROUPER software is disregarding the ICD–9–CM code that identifies the selected HAC in making the MS–DRG assignment for that claim. For example, there were 83 cases in which the ICD–9–CM codes for the Foreign Object Retained After Surgery HAC category were present, but the presence of other secondary diagnoses that were MCCs or CCs resulted in no change to the MS–DRG assignment. Chart E shows that a total of 6,074 cases did not have a change in the MS–DRG assignment because of the presence of other reported MCCs and CCs.

(2) Two Severity Levels Where HAC Does Not Impact MS–DRG Assignment

Column E (Number of MS–DRGs with Two Severity Levels Where HAC Does Not Impact MS–DRG Assignment) shows the frequency with which discharges with a HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because the MS–DRG is subdivided solely by the presence or absence of an MCC. A claim with a HAC and a POA indicator of either "N" or "U" may be assigned to an MS–DRG that is subdivided solely by the presence or absence of an MCC. In such cases, removing a HAC ICD–9–CM CC code will not lead to further changes in the MS–DRG assignment. Examples of these MS–DRG subdivisions are shown in the footnotes to the chart and include the following examples:

- MS–DRGs 100 and 101 (Seizures with or without MCC, respectively)
- MS–DRGs 102 and 103 (Headaches with or without MCC, respectively)

The codes that fall under the HAC category of Foreign Object Retained After Surgery are CCs. If this case were assigned to a MS–DRG with an MCC subdivision such as MS–DRGs 100 and 101, the presence of the HAC code would not affect the MS–DRG severity level assignment. In other words, if the Foreign Object Retained After Surgery code were the only secondary diagnosis reported, then the case would be assigned to MS–DRG 101. If the POA indicator was "N," the HAC Foreign Object Retained After Surgery code would be ignored in the MS–DRG assignment logic. Despite the fact that the code was ignored, the case would still be assigned to the same, lower severity level MS–DRG. Therefore, there would be no impact on the MS–DRG assignment.

Column E in Chart E below shows that there were 1,446 cases where the HAC code was "N" or "U" and the MS–DRG assignment did not change because the case was already assigned to the lowest severity level.

(3) No Severity Levels

Column F (Number of MS–DRGs with No Severity Levels) shows the frequency with which discharges with an HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because the MS–DRG is not subdivided by severity levels. A claim with a HAC and a POA of "N" or "U" may be assigned to a MS–DRG with no severity levels. For instance, MS–DRG 311 (Angina Pectoris) has no severity level subdivisions; this MS–DRG is not split based on the presence of an MCC or a CC. If a patient assigned to this MS–DRG develops a secondary diagnosis such as a Stage III pressure ulcer after admission, the condition would be considered to be a HAC. The code for the Stage III pressure ulcer would be ignored in the MS–DRG assignment because the condition developed after the admission (the POA indicator was "N"). Despite the fact that the ICD–9–CM code for the HAC Stage III pressure ulcer was ignored, the MS–DRG assignment would not change. The case would still be assigned to MS–DRG 311. Chart E below shows that 818 cases reporting a HAC-associated secondary diagnosis did not undergo a change in the MS–DRG assignment based on the fact that the case was assigned to a MS–DRG that had no severity subdivisions (that is, the MS–DRG is not subdivided based on the presence or absence of an MCC or a CC, rendering the presence of the HAC irrelevant for payment purposes).

(4) MS–DRG Logic

Column G (MS–DRG Logic Issues) shows the frequency with which a HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because of MS–DRG assignment logic. There were seven discharges where the HAC criteria were met and the HAC logic was applied, however, due to the structure of the MS–DRG logic, these cases did not result in MS–DRG reassignment. These cases may appear similar to those discharges where the MS–DRG is subdivided into two severity levels by the presence or absence of an MCC and did not result in MS–DRG reassignment; however, these discharges differ slightly in that the MS–DRG logic also considers specific procedures that were reported on the claim. In other words, for certain MS–DRGs, a procedure may be considered the equivalent of an MCC or CC. The presence of the procedure code dictates the MS–DRG assignment despite the presence of the HAC-associated secondary diagnosis code with a POA indicator of "N" or "U".

For example, a claim with the principal diagnosis code of 441.1 (Thoracic aneurysm, ruptured) with HAC-associated secondary diagnosis code of 996.64 (Infection and inflammatory reaction due to indwelling urinary catheter) and diagnosis code 599.0 (Urinary tract infection, site not specified), having POA indicators of "Y", "N", "N", respectively, and procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) results in an assignment to MS–DRG 237 (Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair). In this case, the thoracic aortic aneurysm repair is what dictated the MS–DRG assignment and the presence of the HAC-associated secondary diagnosis code, 996.64, did not affect the MS–DRG assigned. Other examples of MS–DRGs that are subdivided in this same manner are as follows:

- MS–DRG 029 (Spinal procedures with CC or Spinal Neurostimulators)
- MS–DRG 129 (Major Head & Neck Procedures with CC/MCC or Major Device)
- MS–DRG 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ Vessels/Stents)

Column G in the chart below shows that four of the seven cases that did not result in MS–DRG reassignment due to the MS–DRG logic were in the Catheter Associated UTI HAC category, one case was in the Foreign Body Retained after

Surgery HAC Category, one case was in the Falls and Trauma HAC category, and one case was in the Vascular Catheter-Associated Infection HAC Category.

In conclusion, a total of 8,345 cases (6,074 + 1,446 + 818 + 7) did not have a change in MS–DRG assignment, regardless of the presence of a HAC. The reasons described above explain why only 3,038 cases had a change in MS–DRG assignment despite the fact that there were 11,383 HAC cases with a POA of "N" or "U."

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CHART E.—REASONS HAC DID NOT CHANGE MS-DRG ASSIGNMENT OCTOBER 2008 THROUGH JUNE 2009

Selected HAC Category	Number of Discharges with This Condition as Secondary Diagnosis (Column A)	Number of Discharges Identified as a HAC (Column B	Number of HAC Discharges That Change MS-DRG Due to HAC (Column C)	HAC Discharges That Do Not Change MS-DRG			
				Number of Other MCCs/CCs That Prevent Reassign-ment (Column D)	Number of MS-DRGs with Two Severity Levels Where HAC Does Not Impact MS-DRG Assignment* (Column E)	Number of MS-DRGs with No Severity Levels (Column F)	Other MS-DRG Logic Issues ** (Column G)
1. Foreign Object Retained After Surgery – CC	378	172	40	83	42	6	1
2. Air Embolism – MCC	29	23	12	9	0	2	0
3. Blood Incompatibility-CC	23	8	0	4	3	1	0
4. Pressure Ulcer Stages III & IV – MCC	76,041	960	337	481	0	142	0
5. Falls and Trauma – MCC & CC	109,728	3,852	1,476	1,762	367	246	1
6. Catheter-Associated UTI- CC	11,424	1,896	197	1,326	250	119	4
7. Vascular Catheter-Associated Infection – CC	5,470	2,107	23	1,717	122	244	1
8. Poor Glycemic Control – MCC & CC	10,937	319	98	187	1	33	0
9A. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) – MCC	29	21	5	13	0	3	0

Selected HAC Category	Number of Discharges with This Condition as Secondary Diagnosis (Column A)	Number of Discharges Identified as a HAC (Column B	Number of HAC Discharges That Change MS-DRG Due to HAC (Column C)	HAC Discharges That Do Not Change MS-DRG			
				Number of Other MCCs/CCs That Prevent Reassign-ment (Column D)	Number of MS-DRGs with Two Severity Levels Where HAC Does Not Impact MS-DRG Assignment* (Column E)	Number of MS-DRGs with No Severity Levels (Column F)	Other MS-DRG Logic Issues ** (Column G)
9B. Surgical Site Infection Following Certain Orthopedic Procedures – CC	199	123	4	68	48	3	0
9C. Surgical Site Infection Following Bariatric Surgery for Obesity – CC	12	10	1	9	0	0	0
10. Pulmonary Embolism & DVT Orthopedic – MCC & CC	2,494	1,892	845	415	613	19	0
Total[1]	216,764	11,383	3,038	6,074	1446	818	7

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
*Examples where an HAC classified as a CC would not impact the DRG assignment if it were removed. The MS-DRG is subdivided by the presence or absence of an MCC. A CC would not impact this DRG assignment.
MS-DRGs 100 and 101 (Seizures with or without MCC, respectively)
MS-DRGs 102 and 103 (Headaches with or without MCC, respectively)
**Cases where HAC did not change MS-DRG assignment because of the MS-DRG logic.
MS-DRG 029 (Spinal Procedures with CC or Spinal Neurostimulators)
MS-DRG 129 (Major Head & Neck Procedures with CC/MCC or Major Device)

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009

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f. Preliminary RTI Analysis of Coding Changes for HAC-Associated Secondary Diagnoses for Current HACs

In addition to studying claims from October 2008 through June 2009, RTI evaluated claims data from 2 years prior to determine if there were significant changes in the number of discharges with a HAC being reported as a secondary diagnosis. To provide consistency with the FY 2009 data studied, RTI examined claims using discharge dates from October 2006 through June 2007 (for FY 2007) and October 2007 through June 2008 (for FY 2008) and compared these data to the FY 2009 data.

RTI's analysis found that there was an increase in the reporting of secondary diagnoses that are currently designated as HACs from FY 2007 to FY 2008. The most significant increase was in the Falls and Trauma HAC category, with 108,397 discharges being reported in FY 2007, while 116,832 discharges were reported in FY 2008, an increase of 8,435 cases.

However, the analysis found that there was a decrease in reported HAC-associated secondary diagnoses from FY 2008 to FY 2009. The most significant decrease was in the Falls and Trauma HAC category, with 116,832 discharges being reported in FY 2008, while 109,246 discharges were reported in FY 2009, a decrease of 7,586 cases. We point out that because diagnosis codes for the Pressure Ulcer Stages III & IV HAC did not become effective until October 1, 2008, there are no data available for FY 2007 or FY 2008.

We refer readers to the RTI detailed report for all the conditions in each fiscal year (FY 2007 through FY 2009) as described above at the following Web site: *http://www.rti.org/reports/cms/.*

g. Preliminary RTI Analysis of Estimated Net Savings for Current HACs

RTI determined preliminary estimates of the net savings generated by the HAC payment policy based on MedPAR claims from October 2008 through June 2009 for the 9-month period.

(1) Net Savings Estimation Methodology

The payment impact of a HAC is the difference between the IPPS payment amount under the initially assigned MS–DRG and the amount under the reassigned MS–DRG. The amount for the reassigned MS–DRG appears on the MedPAR files. To construct this, RTI modeled the IPPS payments for each MS–DRG following the same approach that we use to model the impact of IPPS annual rule changes. Specifically, RTI replicated the payment computations carried out in the IPPS PRICER program using payment factors for IPPS providers as identified in various CMS downloaded files. The files used are as follows:

- Version 26 of the Medicare Severity GROUPER software (applicable to discharges between October 1, 2008 and September 30, 2009). IPPS MedPAR claims were run through this file to obtain needed HAC–POA output variables.
- The FY 2009 MS–DRG payment weight file. This file includes the weights, geometric mean length of stay (GLOS), and the postacute transfer payment indicators.
- CMS standardized operating and capital rates. Tables 1A through 1C, as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009,* include the full update and reduced update amounts, as well as the information needed to compute the blended amount for providers located in Puerto Rico.
- The IPPS impact files for FY 2009, also as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/.* This file includes the wage index and geographic adjustment factors, plus the provider type variable to identify providers qualifying for alternative hospital-specific amounts and their respective HSP rates.
- The IPPS impact files for FY 2010, as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/10FR/.* This file includes indirect medical education (IME) and disproportionate share (DSH) percent adjustments that were in effect as of March 2009.
- CMS historical provider-specific files (PSF). This includes the indicator to identify providers subject to the full or reduced standardized rates and the applicable operating and capital cost-to-charge ratios. An SAS version was downloaded from the Web site at: *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp.*

There were 50 providers with discharges in the final HAC analysis file that did not appear in the FY 2009 impact file, of which 11 also did not appear in the FY 2010 impact file. For these providers, we identified the geographic CBSA from the historical PSF and assigned the wage index using values from Tables 4A and 4C as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/.* For providers in the FY 2010 file but not the FY 2009 file, we used IME and DSH rates from FY 2010. The 11 providers in neither impact file were identified as non-IME and non-DSH providers in the historical PSF file.

The steps for estimating the HAC payment impact are as follows:

Step 1: Re-run the Medicare Severity GROUPER on all records in the analysis file. This is needed to obtain information on actual HAC-related MS–DRG reassignments in the file, and to identify the CCs and MCCs that contribute to each MS–DRG assignment.

Step 2: Model the base payment and outlier amounts associated with the initial MS–DRG if the HAC were excluded using the computations laid out in the CMS file "Outlier Example FY2007 new.xls," as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage,* and modified to accommodate FY 2009 factors. RTI's first round of computations treated all claims as though paid under standard IPPS rules without adjusting for short-stay transfers or HSP amounts.

Step 3: Model the base payment and outlier amounts associated with the final MS–DRG where the HAC was excluded using the computations laid out in the CMS file "Outlier Example FY2007 new.xls," as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage* and modified to accommodate FY 2009 factors. RTI's first round of computations treated all claims as though paid under standard IPPS rules without adjusting for short-stay transfers or HSP amounts.

Step 4: Compute MS–DRG base savings as the difference between the nonoutlier payments for the initial and final MS–DRGs. Compute outlier amounts as the difference in outlier amounts due under the initial and final reassigned MS–DRG. Compute net savings due to HAC reassignment as the sum of base savings plus outlier amounts.

Step 5: Adjust the model to incorporate short-stay transfer payment adjustments.

Step 6: Adjust the model to incorporate hospital-specific payments for qualifying rural providers receiving the hospital-specific payment rates.

It is important to mention that using the methods described above, the MS–DRG and outlier payments amounts that are modeled for the final assigned MS–DRG do not always match the DRG price and outlier amounts that appear in the MedPAR record. There are several reasons for this. Some discrepancies are caused by using single wage index, IME and DSH factors for the full period

covered by the discharges, when in practice these payment factors can be adjusted for individual providers during the course of the fiscal year. In addition, RTI's approach disregards any Part A coinsurance amounts owed by individual beneficiaries with greater than sixty covered days in a spell of illness. Five percent of all HAC discharges showed at least some Part A coinsurance amount due from the beneficiary, although less than two percent of reassigned discharges (55 cases in the analysis file) showed Part A coinsurance amounts due. Any Part A coinsurance payments would reduce the actual savings incurred by the Medicare program.

There are also a number of less common special IPPS payment situations that are not factored into RTI's modeling. These could include new technology add-on payments, payments for blood clotting factors, reductions for replacement medical devices, adjustments to the capital rate for new providers, and adjustments to the capital rate for certain classes of providers who are subject to a minimum payment level relative to capital cost.

(2) Net Savings Estimate

Chart F below summarizes the estimated net savings of current HACs based on MedPAR claims from October 2008 through 2009, based on the methodology described above. Column A shows the number of discharges where an MS–DRG reassignment for each HAC category occurred. For example, there were 12 discharges with an Air Embolism that resulted in an actual MS–DRG reassignment. Column B shows the total net savings caused by MS–DRG reassignments for each HAC category. Continuing with the example of Air Embolism, the chart shows that the 12 discharges with an MS–DRG reassignment resulted in a total net savings of $148,394. Column C shows the net savings per discharge for each HAC category. For the Air Embolism HAC category, the net savings per discharge is $12,366.

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CHART F.—ESTIMATED NET SAVINGS OF CURRRENT HACs OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	Number of Discharges That Change MS-DRG Due to HAC (Column A)	Net Savings (In Dollars) (Column B)	Net Savings Per Discharge (In Dollars) (Column C)
1. Foreign Object Retained After Surgery	40	$142,681	$3,567
2. Air Embolism	12	$148,394	$12,366
3. Blood Incompatibility	0	$0	$0
4. Pressure Ulcer Stages III & IV	337	$1,869,956	$5,549
a. Stage III	286	$1,552,057	$5,427
b. Stage IV	57	$340, 263	$5,970
5. Falls and Trauma	1,476	$7,580,774	$5,136
a. Fracture	1,267	$6,523,144	$5,148
b. Dislocation	3	$13,984	$4,661
c. Intracranial Injury	213	$1,089,813	$5,116
d. Crushing Injury	0	$0	$0
e. Burn	6	$21,639	$3,607
f. Shock	1	$12,749	$12,749
6. Catheter-Associated UTI	197	$567,933	$2,883
7. Vascular Catheter-Associated Infection	23	$74,586	$3,243
8. Poor Glycemic Control	98	$489,733	$4,997
9a. SSI Mediastinitis CABG	5	$54,276	$10,855
9b. SSI Orthopedic	4	$39,363	$9,841
9c. SSI Bariatric	1	$2,381	$2,381
10. Pulmonary Embolism & DVT Orthopedic	845	$5,605,229	$6,633
Total[1]	3,038	$16,442,185[2]	$5,456

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
[2] Total net savings is adjusted by -$133,122 for 15 claims that have multiple HACs.

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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As shown in Chart F above, the total net savings calculated for the 9-month period from October 2008 through June 2009 was roughly $16.44 million. The three HACs with the largest number of discharges resulting in MS–DRG reassignment, Falls and Trauma, Orthopedic PE/DVT, and Pressure Ulcer Stages III & IV, generated $15.10 million of net savings for the 9-month period. Estimated net savings for the 9-month period associated with the Falls and Trauma category were $7.58 million. Estimated net savings associated with Orthopedic PE/DVT for the 9-month period were $5.61 million. Estimated net savings for the 9-month period associated with Pressure Ulcer Stages III & IV were $1.87 million.

The mean net savings per discharge calculated for the 9-month period from October 2008 through June 2009 was roughly $5,456. The HAC categories of Air Embolism; SSI, Mediastinitis, Following Coronary Artery Bypass Graft (CABG); and SSI Following Certain Orthopedic Procedures had the highest net savings per discharge, but represented a small proportion of total net savings because the number of discharges that resulted in MS–DRG reassignment for these HACs was low. With the exception of Blood Incompatibility, where no savings occurred because no discharges resulted in MS–DRG reassignment, SSI Following Bariatric Surgery for Obesity and Catheter-Associated UTI had the lowest net savings per discharge.

We refer readers to the RTI detailed report available at the following Web site: *http://www.rti.org/reports/cms/*.

As mentioned previously, an extremely small number of cases in the 9-month period of FY 2009 analyzed by RTI had multiple HACs during the same stay. In reviewing our 7.17 million claims, RTI found 47 cases where two HACs were reported on the same admission as noted in section II.F.3.g.(2) of this preamble. Of these 47 claims, 15 resulted in MS–DRG reassignment. Chart G below summarizes these cases. There were 15 cases that had two HACs not POA that resulted in an MS–DRG reassignment. Of these, 5 discharges involved Pressure Ulcer Stages III & IV and Falls and Trauma and 4 discharges involved Orthopedic PE/DVT and Falls and Trauma.

CHART G—CLAIMS WITH MORE THAN ONE HAC SECONDARY DIAGNOSIS WHERE MS–DRG REASSIGNMENT OCCURRED OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	4. Pressure ulcer stages III & IV—MCC	5. Falls and trauma—MCC & CC	6. Catheter-associated UTI—CC
3. Blood Incompatibility—CC		1	
5. Falls and Trauma—MCC & CC	5		
6. Catheter-Associated Urinary Tract Infection (UTI)—CC	1	1	
7. Vascular Catheter-Associated Infection—CC		1	1
10. Pulmonary Embolism & DVT Orthopedic—MCC	1	4	
Total	7	7	1

As we discuss in section II.F.1.b. of this preamble, implementation of this policy is the part of an array of Medicare VBP tools that we are using to promote increased quality and efficiency of care. We point out that a decrease over time in the number of discharges where these conditions are not POA is a desired consequence. We recognize that estimated net savings would likely decline as the number of such discharges decline. However, we believe that the sentinel effect resulting from CMS identifying these conditions is critical. (We refer readers to section IV.A. of this preamble for a discussion of the inclusion of the incidence of these conditions in the RHQDAPU program.) It is our intention to continue to monitor trends associated with the frequency of these HACs and the estimated net payment impact through RTI's program evaluation and possibly beyond.

h. Previously Considered Candidate HACs—Preliminary RTI Analysis of Frequency of Discharges and POA Indicator Reporting

RTI evaluated the frequency of conditions previously considered, but not adopted as HACs in prior rulemaking, that were reported as secondary diagnoses (across all 7.17 million discharges) as well as the POA indicator assignments for these conditions. Chart H below indicates that the three previously considered candidate conditions most frequently reported as a secondary diagnosis were: (1) Clostridium Difficile-Associated Disease (CDAD), which demonstrated the highest frequency, with a total of 66,502 secondary diagnoses codes being reported for that condition, of which 23,323 reported a POA indicator of "N"; (2) Staphylococcus aureus Septicemia, with a total of 17,662 secondary diagnoses codes being reported for that condition, with 3,949 of those reporting a POA indicator of "N"; and (3) Iatrogenic Pneumothorax, with a total of 16,765 secondary diagnoses codes being reported for that condition, with 14,604 of those reporting a POA indicator of "N." As these three conditions had the most significant impact for reporting a POA indicator of "N," it is reasonable to believe that these same three conditions would have the greatest number of potential MS–DRG reassignments. The frequency of discharges for the previously considered HACs that could lead to potential changes in MS–DRG assignment is discussed in the next section. We take this opportunity to remind readers that because more than one previously considered HAC diagnosis code can be reported per discharge (on a single claim) that the frequency of these diagnosis codes may be more than the actual number of discharges with a previously considered candidate condition reported as a secondary diagnosis.

CHART H.--POA STATUS OF PREVIOUSLY CONSIDERED "CANDIDATE" HAC CONDITIONS--OCTOBER 2008 THROUGH JUNE 2009

Previously Considered HAC Condition	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA = N		POA = U		POA =Y		POA = W	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Clostridium Difficile-Associated Disease (CDAD)	66,502	23,323	35.1	379	0.6	42,702	64.2	98	0.1
2. Delirium	528	136	25.8	0	0.0	392	74.2	0	0.0
3. Legionnaire's Disease	249	14	5.6	3	1.2	232	93.2	0	0.0
4. Staphylococcus aureus Septicemia	17,662	3,949	44.4	45	0.5	13,641	154.8	27	0.3
5. Methicillin-Resistant Staphylococcus aureus	54,744	1,834	6.0	136	0.9	52,737	192.6	37	0.5
6. Iatrogenic Pneumothorax	16,765	14,604	87.1	12	0.1	2,149	12.8	0	0.0
7. Ventilator-Associated Pneumonia	3,253	2,576	79.2	4	0.1	672	20.7	1	0.0

In Chart I below, Column A shows the number of discharges for each previously considered candidate HAC category when the condition was reported as a secondary diagnosis. For example, there were 66,502 discharges that reported CDAD as a secondary diagnosis. Previously considered candidate HACs reported with a POA indicator of "N" or "U" may cause MS–DRG reassignment (which would result in reduced payment to the facility). Column C shows the discharges for each previously considered candidate HAC reported with a POA indicator of "N" or "U." Continuing with the example of CDAD, Chart I shows that, of the 66,502 discharges, 23,702 discharges (35.64 percent) had a POA indicator of "N" or "U." Therefore, there were a total of 23,702 discharges that could potentially have had an MS–DRG reassignment. Column E shows the number of discharges where an actual MS–DRG reassignment could have occurred; the number of discharges with CDAD that could have resulted in actual MS–DRG reassignments is 739 (3.12 percent). Thus, while there were 23,702 discharges with CDAD reported with a POA indicator of "N" or "U" that could potentially have had an MS–DRG reassignment, the result was 739 (3.12 percent) potential MS–DRG reassignments. As discussed above, there are a number of reasons why a condition reported with a POA indicator of "N" or "U" would not result in a MS–DRG reassignment.

In summary, Chart I below demonstrates there were a total of 159,485 discharges with a previously considered candidate HAC reported as a secondary diagnosis. Of those, 47,010 discharges were reported with a POA indicator of "N" or "U." The total number of discharges that could have resulted in MS–DRG reassignments is 2,932.

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CHART I.--PREVIOUSLY CONSIDERED "CANDIDATE" HAC DISCHARGE FREQUENCIES--OCTOBER 2008 THROUGH JUNE 2009

Previously Considered HAC Condition	Discharges with this Condition as Secondary Diagnosis[2]		Discharges with this Condition Not Present on Admission (POA = "N" or "U")[3]		Cases that Could Change MS-DRG Due to Previously Considered Candidate HAC[4]	
	Number (Column A)	Percent (Column B)	Number (Column C)	Percent (Column D)	Number (Column E)	Percent (Column F)
1. Clostridium Difficile-Associated Disease (CDAD)	66,502	0.93%	23,702	35.64%	739	3.12%
2. Delirium	528	0.01%	136	25.76%	11	8.09%
3. Legionnaire's Disease	249	0.00%	17	6.83%	1	5.88%
4. Staphylococcus aureus Septicemia	17,630	0.25%	3,991	22.64%	90	2.26%
5. Methicillin-Resistant Staphylococcus aureus (MRSA)	54,558	0.76%	1,968	3.61%	2	0.10%
6. Iatrogenic Pneumothorax	16,765	0.23%	14,616	87.18%	2,088	14.29%
7. Ventilator-Associated Pneumonia	3,253	0.05%	2,580	79.31%	1	0.04%
Total[1]	159,485		47,010		2,932	

[1] Discharges can appear in more than one row.
[2] Percent computed relative to total cases "at risk," which is 7,175,139 for all candidate conditions.
[3] Percent computed relative to discharges with condition as a secondary diagnosis.
[4] Percent computed relative to discharges with condition as a secondary diagnosis and identified as a previously considered HAC (that is, coded as not present on admission).

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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i. Current and Previously Considered Candidate HACs—RTI Report on Evidence-Based Guidelines

The RTI program evaluation includes a report that provides references for all evidence-based guidelines available for each of the selected and previously considered candidate HACs that provide recommendations for the prevention of the corresponding conditions. Guidelines were primarily identified using the AHRQ National Guidelines Clearing House (NGCH) and the CDC, along with relevant professional societies. Guidelines published in the United States were used, if available. In the absence of U.S. guidelines for a specific condition, international guidelines were included.

Evidence-based guidelines that included specific recommendations for the prevention of the condition were identified for each of the 10 selected conditions. In addition, evidence-based guidelines were also found for the previously considered candidate conditions.

RTI prepared a final report to summarize its findings regarding evidence-based guidelines, which can be found on the Web site at: *http://www.rti.org/reports/cms.*

j. Proposals Regarding Current HACs and Previously Considered Candidate HACs

We believe that the RTI analysis summarized above does not provide additional information that would require us to change our previous determinations regarding either current HACs (as described in section II.F.2. of this preamble) or previously considered candidate HACs in the FY 2008 IPPS final rule with comment period and FY 2009 IPPS final rule (72 FR 47200 through 47218 and 73 FR 48471 through 48491, respectively). Accordingly, we are not proposing to add or remove categories of HACs at this time, although we note that we are proposing

to revise the Blood Incompatibility HAC category as discussed in section II.F.2. of this preamble. (We also note that, as discussed in section II.F.3.b. of this preamble, we are not proposing to change our current policy regarding the treatment of the "U" POA indicator.) However, we continue to encourage public dialogue about refinements to the HAC list.

We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) and to section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48491) for detailed discussion supporting our determination regarding each of these conditions.

G. Proposed Changes to Specific MS–DRG Classifications

We are inviting public comment on each of the MS–DRG classification proposed changes described below, as well as our proposals to maintain certain existing MS–DRG classifications, which are also discussed below. In some cases, we are proposing changes to the MS–DRG classifications based on our analysis of claims data. In other cases, we are proposing to maintain the existing MS–DRG classification based on our analysis of claims data.

1. Pre-Major Diagnostic Categories (MDCs)

a. Postsurgical Hypoinsulinemia (MS–DRG 008 (Simultaneous Pancreas/Kidney Transplant)

Diabetes mellitus is a pancreatic disorder in which the pancreas fails to produce sufficient insulin, or in which the body cannot process insulin. Many patients with diabetes will eventually experience complications of the disease, including poor kidney function. When these patients show signs of advanced kidney disease, they are usually referred for transplant evaluation. Currently, many doctors recommend that individuals with diabetes being evaluated for kidney transplantation also be considered for pancreas transplantation. A successful pancreas transplant may prevent, stop, or reverse the complications of diabetes.

Occasionally, secondary diabetes may be surgically induced following a pancreas transplant. This condition would be identified by using ICD–9–CM diagnosis code 251.3 (Postsurgical hypoinsulinemia). However, currently the list of principal diagnosis codes assigned to surgical MS–DRG 008 (Simultaneous Pancreas/Kidney Transplant) does not include diagnosis code 251.3. Therefore, when diagnosis code 251.3 is assigned to a case as a principal diagnosis, the case is not assigned to MS–DRG 008. Instead, these cases are grouped to MS–DRG 652 (Kidney Transplant) under MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). In addition, the use of diagnosis code 251.3 as a principal diagnosis without a secondary diagnosis of diabetes mellitus and with a procedure code for pancreas transplant only during that admission results in assignment of the case to MS–DRG 628, 629, or 630 (Other Endocrine, Nutritional & Metabolic Operating Room Procedures with MCC, with CC, and without CC/MCC, respectively) under MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders).

We believe that the exclusion of diagnosis code 251.3 from the list of principal diagnosis codes assigned to surgical MS–DRG 008 is an error of omission. Therefore, we are proposing to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 008. As a conforming change, we also are proposing to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 010 (Pancreas Transplant).

b. Bone Marrow Transplants

We received two requests to review whether cost differences between an autologous bone marrow transplant (where the patient's own bone marrow or stem cells are used) and an allogeneic bone marrow transplant (where bone marrow or stem cells come from either a related or unrelated donor) necessitate the creation of separate MS DRGs to more appropriately account for the clinical nature of the services being rendered as well as the costs. One of the requestors stated that there are dramatic differences in the costs between the two types of transplants where allogeneic cases are significantly more costly.

Bone marrow transplantation and peripheral blood stem cell transplantation are used in the treatment of certain cancers and bone marrow diseases. These procedures restore stem cells that have destroyed by high doses of chemotherapy and/or radiation treatment. Currently, all bone marrow transplants are assigned to MS–DRG 009 (Bone Marrow Transplant).

We performed an analysis of the FY 2009 MedPAR data and found 1,664 total cases assigned to MS–DRG 009 with average costs of approximately $43,877 and an average length of stay of approximately 21 days. Of these MS–DRG 009 cases, 395 of them were allogeneic bone marrow transplant cases reported with one of the following ICD–9–CM procedure codes: 41.02 (Allogeneic bone marrow transplant with purging); 41.03 (Allogeneic bone marrow transplant without purging); 41.05 (Allogeneic hematopoietic stem cell transplant without purging); 41.06 (Cord blood stem cell transplant); or 41.08 (Allogeneic hematopoietic stem cell transplant). The average costs of these allogeneic cases, approximately $64,845, were higher than the overall average costs of all cases in MS–DRG 009, approximately $43,877. The average length of stay for the allogeneic cases, approximately 28 days, was slightly higher than the average length of stay for all cases assigned to MS–DRG 009, approximately 21 days.

We found 1,269 autologous bone marrow transplant cases reported with one of the following ICD–9–CM procedure codes: 41.00 (Bone marrow transplant, not otherwise specified); 41.01 (Autologous bone marrow transplant without purging); 41.04 (Autologous hematopoietic stem cell transplant without purging); 41.07 (Autologous hematopoietic stem cell transplant with purging); or 41.09 (Autologous bone marrow transplant with purging). The average costs of these cases, approximately $37, 350, was less than the overall average costs of all cases in MS–DRG 009 and the average costs associated with the allogeneic bone marrow transplant cases. The average length of stay, of approximately 19 days, was less than the average lengths of stay for all the cases assigned to MS–DRG 009 and for the allogeneic bone marrow transplant cases. We included in our analysis of the autologous bone marrow transplants cases, 5 cases that were reported with procedure code 41.00 (Bone marrow transplant, not otherwise specified). These 5 cases had average costs of approximately $41,084 and an average length of stay of approximately 12 days, which was similar to the other autologous bone marrow transplant cases.

The table below illustrates our findings:

MS–DRG	Number of cases	Average length of stay	Average cost
009—All cases	1,664	21.22	$43,877
009—Cases with allogeneic bone marrow transplants	395	27.7	64,845
009—Cases with autologous bone marrow transplants	1,269	19.1	37,350

As a result of our analysis, the data support the requestor's suggestion that there are cost differences associated with the autologous bone marrow transplants and allogeneic bone marrow transplants and warrants a separate MS–DRG for these procedures. Therefore, we are proposing to delete MS–DRG 009 and create two new MS–DRGs: MS–DRG 014 (Allogeneic Bone Marrow Transplant) and MS–DRG 015 (Autologous Bone Marrow Transplant).

Proposed MS–DRG 014 would include cases reported with one of the following ICD–9–CM procedure codes:

- 41.02, Allogeneic bone marrow transplant with purging
- 41.03, Allogeneic bone marrow transplant without purging
- 41.05, Allogeneic hematopoietic stem cell transplant without purging
- 41.06, Cord blood stem cell transplant
- 41.08, Allogeneic hematopoietic stem cell transplant

Proposed MS–DRG 015 would include cases reported with one of the following ICD–9–CM procedure codes:

- 41.00 (Bone marrow transplant, not otherwise specified)
- 41.01 (Autologous bone marrow transplant without purging)
- 41.04 (Autologous hematopoietic stem cell transplant without purging)
- 41.07 (Autologous hematopoietic stem cell transplant with purging)
- 41.09 (Autologous bone marrow transplant with purging)

2. MDC 1 (Nervous System): Administration of Tissue Plasminogen Activator (tPA) (rtPA)

During the comment period for the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we received a public comment that had not been the subject of a proposal in that proposed rule. The commenter had requested that CMS conduct an analysis of diagnosis code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) under MDC 1 (Diseases and Disorders of the Nervous System). Diagnosis code V45.88 was created for use beginning October 1, 2008, to identify patients who are given tissue plasminogen activator (tPA) at one institution and then transferred and admitted to a comprehensive stroke center for further care. This situation is referred to as the "drip-and-ship" issue that was discussed at detail in the FY 2009 IPPS final rule (73 FR 48493).

According to the commenter, the concern at the receiving facilities is that the costs associated with [caring for] more complex stroke patients that receive tPA are much higher than the cost of the drug, presumably because stroke patients initially needing tPA have more complicated strokes and outcomes. However, because these patients do not receive the tPA at the second or transfer hospital, the receiving hospital will not be assigned to one of the higher weighted tPA stroke MS–DRGs when it admits these patients whose care requires the use of intensive resources. The MS–DRGs that currently include codes for the use of tPA are: 061 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC); 062 (Acute Ischemic Stroke with Use of Thrombolytic Agent with CC); and 063 (Acute Ischemic Stroke with Use of Thrombolytic Agent without CC/MCC). These MS–DRGs have higher relative weights than the next six MS–DRGs relating to brain injury in the hierarchy. The commenter requested an analysis of the use of diagnosis code V45.88 reflected in the MedPAR data for FY 2009 and FY 2010. The commenter believed that the data would show that the use of this code could potentially result in a new MS–DRG or a new set of MS–DRGs in FY 2011.

In addressing this public comment in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43798), we noted that the comment was out of scope for the FY 2010 proposed rule and reiterated that the deadline for requesting data review and potential MS–DRG changes had been the previous December. We are now able to address the commenter's concern because we have been able to conduct an analysis of MedPAR claims data for this diagnosis code for this proposed rule.

For this proposed rule, we undertook an analysis of MedPAR claims data for FY 2009. For our analysis, we did not include claims for patient cases assigned to MS–DRGs 061, 062, or 063 because patients whose cases were assigned to these MS–DRGs would have been given the tPA at the initial hospital, with assignment of procedure code 99.10 (Injection or infusion of thrombolytic agent), prior to their transfer to a comprehensive stroke center. The tPA should not have been given at the receiving hospital; therefore, inclusion of code 99.10 on their claims would constitute erroneous coding. Likewise, we did not include MS–DRGs 067 and 068 (Nonspecific CVA & Precerebral Occlusion without Infarction with MCC, and without MCC, respectively), or MS–DRG 069 (Transient Ischemia). Claims assigned to MS–DRGs 067, 068, and 069 are unlikely to contain cases in which tPA had been administered.

Our data analysis included MS–DRGs 064, 065, and 066 (Intracranial Hemorrhage or Cerebral Infarction with MCC, with CC, and without CC/MCC, respectively) because claims involving diagnosis code V45.88 would be properly reported in the data for these MS–DRGs for FY 2009. The following table reflects the results of our analysis of the MedPAR data in which diagnosis code V45.88 was reported as a secondary diagnosis for FY 2009.

MS–DRG	Number of cases	Average length of stay	Average cost
MS–DRG 064—All Cases	65,884	6.80	$11,305
MS–DRG 064—Cases with secondary diagnosis code V45.88	249	7.00	12,285
MS–DRG 065—All Cases	96,274	4.75	7,264
MS–DRG 065—Cases with secondary diagnosis code V45.88	448	5.06	8,732
MS–DRG 066—All Cases	62,337	3.29	5,291

MS–DRG	Number of cases	Average length of stay	Average cost
MS–DRG 066—Cases with secondary diagnosis code V45.88	210	3.35	6,325

Based on our review of the data for all of the cases in MS–DRGs 064, 065, and 066, compared to the subset of cases containing the V45.88 secondary diagnosis code, we concluded that the movement of cases with diagnosis code V45.88 as a secondary diagnosis from MS–DRGs 064, 065, and 066 into MS–DRGs 061, 062, and 063 is not warranted. We determined that the differences in the average lengths of stay and the average costs are too small to warrant an assignment to the higher weighted MS–DRGs. Likewise, neither the lengths of stay nor the average costs are substantial enough to justify the creation of an additional MS–DRG for transferred tPA cases, or to create separate MS–DRGs that would mirror the MCC, CC or without CC/MCC severity levels.

Therefore, for FY 2011, we are not proposing any change to MS–DRGs 061, 062, 063, 064, 065, or 066, or any change involving the assignment of diagnosis code V45.88.

3. MDC 5 (Diseases and Disorders of the Circulatory System): Intraoperative Fluorescence Vascular Angiography (IFVA) and X–Ray Coronary Angiography in Coronary Artery Bypass Graft Surgery

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR43785 through 43787), we discussed a request we received to reassign cases reporting the use of intraoperative fluorescence vascular angiography (IFVA) with coronary artery bypass graft (CABG) procedures from MS–DRGs 235 and 236 (Coronary Bypass without Cardiac Catheterization with and without MCC, respectively) to MS–DRG 233 (Coronary Bypass with Cardiac Catheterization with MCC) and MS–DRG 234 (Coronary Bypass with Cardiac Catheterization without MCC). Effective October 1, 2007, procedure code 88.59 (Intraoperative fluorescence vascular angiography (IFVA)) was established to describe this technology.

In addition, we also discussed receiving related requests (74 FR 43798 through 43799) that were outside the scope of issues addressed for MDC 5 in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. There were three components to these requests. The first component involved the creation of new MS–DRGs. One request was to create four new MS–DRGs that would differentiate the utilization of resources between intraoperative angiography and IFVA when utilized with CABG. A second request was to create only one new MS–DRG to separately identify the use of intraoperative angiography, by any method, in CABG surgery. The second component involved reviewing the ICD–9–CM procedure codes. Currently, the ICD–9–CM procedure codes do not distinguish between preoperative, intraoperative, and postoperative angiography. Procedure code 88.59 (Intraoperative fluorescence vascular angiography (IFVA)) is one intraoperative angiography technique that allows visualization of the coronary vasculature. The third component involved reassigning cases with procedure code 88.59 to the "Other Cardiovascular MS–DRG"s: MS–DRGs 228, 229, and 230 (Other Cardiothoracic Procedures with MCC, CC, and without CC/MCC, respectively). We stated our intent to consider these requests during the FY 2011 rulemaking process.

After publication of the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we were contacted by one of the requestors, the manufacturer of the IFVA technology. We met with the requestor in mid-November 2009 to discuss evaluating the data for IFVA (procedure code 88.59) again in consideration of a proposal to create new MS–DRGs and to discuss a request for a new procedure code(s).

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

a. New MS–DRGs for Intraoperative Fluorescence Vascular Angiography (IFVA) With CABG

As stated earlier, the manufacturer requested that we create four new MS–DRGs for CABG to distinguish CABG surgeries performed with IFVA and those performed without IFVA. According to the requestor, these four new MS–DRGs would correspond to the existing MS–DRG for CABG but would also include intraoperative angiography. The requestor proposed the following four new MS–DRGs:

MS–DRG XXX (Coronary Bypass with Cardiac Catheterization with MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass with Cardiac Catheterization without MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass without Cardiac Catheterization with MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass without Cardiac Catheterization without MCC with Intraoperative Angiography)

Using claims data from the FY 2009 MedPAR file, we examined cases identified by procedure code 88.59 in MS–DRGs 233, 234, 235, and 236. As shown in the table below, for both MS–DRGs 235 and 236, the cases utilizing IFVA technology (code 88.59) have a shorter length of stay and lower average costs compared to all cases in MS–DRGs 235 and 236. There were a total of 10,281 cases in MS–DRG 235 with an average length of stay of 10.61 days and average costs of $34,639. There were 114 cases identified by procedure code 88.59 with an average length of stay of 10.38 days with average costs of $28,238. In MS–DRG 236, there were a total of 22,410 cases with an average length of stay of 6.37 days and average costs of $23,402; and there were 186 cases identified by procedure code 88.59 with an average length of stay of 6.54 days and average costs of $19,305. Similar to the data reported last year, the data for FY 2009 clearly demonstrate that the IFVA cases (identified by procedure code 88.59) are assigned appropriately to MS–DRGs 235 and 236. We also examined cases identified by procedure code 88.59 in MS–DRGs 233 and 234. Likewise, in MS–DRGs 233 and 234 cases identified by code 88.59 reflect shorter lengths of stay and lower

average costs compared to the remainder of the cases in those MS–DRGs; and there were a total of 16,475 cases in MS–DRG 233 with an average length of stay of 13.47 days and average costs of $42,662. There were 58 cases identified by procedure code 88.59 with an average length of stay of 12.12 days and average costs of $35,940. In MS–DRG 234, there were a total of 23,478 cases with an average length of stay of 8.61 days and average costs of $29,615; and there were 67 cases identified by procedure code 88.59 with an average length of stay of 8.85 days and average costs of $25,379. The data clearly demonstrate the IFVA cases (identified by procedure code 88.59) are appropriately assigned to MS–DRGs 233 and 234.

MS–DRG	Number of cases	Average length of stay	Average cost
235—All cases	10,281	10.61	$34,639
235—Cases with procedure code 88.59	114	10.38	28,238
235—Cases without procedure code 88.59	10,167	10.62	34,711
236—All cases	22,410	6.37	23,402
236—Cases with code procedure 88.59	186	6.54	19,305
236—Cases without procedure code 88.59	22,224	6.37	23,436

MS–DRG	Number of cases	Average length of stay	Average cost
233—All cases	16,475	13.47	$42,662
233—Cases with procedure code 88.59	58	12.12	35,940
233—Cases without procedure code 88.59	16,417	13.47	42,686
234—All cases	23,478	8.61	29,615
234—Cases with procedure code 88.59	67	8.85	25,379
234—Cases without procedure code 88.59	23,411	8.61	29,627

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

In summary, the data do not support moving IFVA cases (procedure code 88.59) from MS–DRGs 235 and 236 to MS–DRGs 233 and 234. Therefore, we are not proposing to make any MS–DRG modifications for cases reporting procedure code 88.59 for FY 2011.

b. New MS–DRG for Intraoperative Angiography, by Any Method, With CABG

We also received a request to create a single MS–DRG for any type of intraoperative angiography utilized in CABG surgery. The requestor suggested the following title for the proposed new MS–DRG: XXX Coronary Bypass with Intraoperative Angiography, by any Method.

Currently, the only ICD–9–CM procedure code that identifies an intraoperative angiography is procedure code 88.59 (Intraoperative fluorescence vascular angiography), as described in the previous section. Due to the structure of the ICD–9–CM procedure classification system, it is not possible to distinguish when other types of angiography are performed intraoperatively. Therefore, we are unable to evaluate any data, other than that for procedure code 88.59, as shown in the tables above. We are not proposing to create a new MS–DRG in FY 2011 for coronary bypass with intraoperative angiography, by any method.

c. New Procedure Codes

In response to our invitation to submit public comments regarding the proposal not to make any MS–DRG modifications for cases reporting procedure code 88.59 in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106–24107), one requestor presented another option involving the creation of new ICD–9–CM procedure codes. According to the requestor, the purpose of these new codes would be to separately identify the two technologies used to perform intraoperative coronary angiography in CABG surgery: X-ray coronary angiography with cardiac catheterization and fluoroscopy versus intraoperative fluorescence coronary angiography (IFVA). The requestor stated that due to the structure of the current codes and MS–DRGs for CABG, it is difficult to identify when x-ray angiography is performed.

X-ray angiography is commonly performed as a separate procedure in a catheterization laboratory. Currently, there are no procedure codes to distinguish if this angiography was performed preoperatively, intraoperatively, and/or postoperatively. We informed the requestor that they could submit a proposal for creating a new procedure code(s) to the ICD–9–CM Coordination and Maintenance Committee for its consideration. Therefore, this topic will be further evaluated through the ICD–9–CM Coordination and Maintenance Committee meeting process.

d. MS–DRG Reassignment of Intraoperative Fluorescence Vascular Angiography (IFVA)

One requestor suggested reassigning procedure code 88.59 (Intraoperative Fluorescence Vascular Angiography), to the "Other Cardiovascular MS–DRGs:" MS–DRGs 228, 229, and 230 (Other Cardiothoracic Procedures with MCC, CC, and without CC/MCC, respectively). The requestor noted that these MS–DRGs have three levels of severity and that other procedures assigned to these MS–DRGs (for example, transmyocardial revascularization) are frequently performed at the same time as a CABG. The requestor believed that reassigning cases that report IFVA (procedure code 88.59) to these MS–DRGs would not result in a significant overpayment to hospitals.

We point out that, in the surgical hierarchy, MS–DRGs 228, 229, and 230 rank higher than MS–DRGs 233, 234, 235, and 236, which were evaluated in the above tables for CABG procedures

performed with IFVA (procedure code 88.59). The surgical hierarchy reflects the relative resource requirements of various surgical procedures. For example, if a CABG surgery were performed along with another procedure currently assigned to MS–DRGs 228, 229, and 230, the case would be assigned to one of the "Other Cardiothoracic Procedures MS–DRGs" (228, 229, and 230) because patients with multiple procedures are assigned to the highest surgical hierarchy to which one of the procedures is assigned.

Therefore, as the data shown above did not demonstrate that IFVA utilized an equivalent (or additional) amount of resources as a cardiac catheterization to warrant a proposal to reassign IFVA cases to MS–DRGs 233 and 234 and the fact that IFVA cases with CABG performed with a procedure assigned to MS–DRGs 228, 229, and 230 would already be grouped to those same MS–DRGs, we are not proposing to reassign cases reporting procedure code 88.59 to MS–DRGs 228, 229, and 230 for FY 2011.

4. MDC 6 (Diseases and Disorders of the Digestive System): Gastrointestinal Stenting

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR43799), we discussed a request we received to create new MS–DRGs in FY 2011 to better identify patients who undergo the insertion of a gastrointestinal stent. The request was considered outside the scope of issues addressed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule; therefore, we stated our intent to consider this request during the FY 2011 rulemaking process.

Gastrointestinal stenting is performed by inserting a tube (stent) into the esophagus, duodenum, biliary tract or colon to reestablish or maintain patency of these structures and allow swallowing, drainage, or passage of waste. The commenter requested that the new MS–DRGs be subdivided into three severity levels (with MCC, with CC, and without CC/MCC) to better align payment rates with resource consumption and improve the clinical coherence of these cases.

In its own analysis using FY 2008 MedPAR data, the commenter identified gastrointestinal stenting cases using relevant diagnosis codes and a combination of procedure codes with revenue code 0278 in MS–DRGs 374, 375, and 376 (Digestive Malignancy with MCC, with CC, and without CC/MCC, respectively), MS–DRGs 391and 392 (Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders with MCC and without MCC, respectively), and MS–DRGs 393, 394, and 395 (Other Digestive System Diagnoses with MCC, with CC, and without CC/MCC, respectively) in MDC 6 (Diseases and Disorders of the Digestive System); and MS–DRGs 435, 436, and 437 (Malignancy of Hepatobiliary System or Pancreas with MCC, with CC, and without CC/MCC, respectively) in MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas).

As stated above, the commenter utilized a combination of procedure codes along with revenue code 0278 for its analysis. There were a total of six procedure codes included, of which, only three (procedure codes 42.81, 51.87, and 52.93) actually describe the insertion of a stent. The complete list of procedure codes is as follows:

- 42.81 (Insertion of permanent tube into esophagus)
- 45.13 (Other endoscopy of small intestine)
- 45.22 (Endoscopy of large intestine through artificial stoma)
- 46.85 (Dilation of intestine)
- 51.87 (Endoscopic insertion of stent (tube) into bile duct)
- 52.93 (Endoscopic insertion of stent (tube) into pancreatic duct)

The commenter aggregated the results by the previously mentioned MS–DRG groupings and did not present results for individual stenting procedures. According to the commenter, mean standardized charges for gastrointestinal stenting procedures were higher than those for nonstenting procedures across all levels of severity of illness. In addition, the commenter believed that the difference in charges was not simply related to the costs of the stents, but rather that the extent of the difference in charges reflected the severity of illness and resource intensity associated with gastrointestinal stenting procedures.

In response to the commenter's request, we point out that we do not utilize revenue codes in our process to evaluate if new MS–DRGs are warranted. The use of revenue codes in the MS–DRG reclassification process would require a major structural change from the current process that has been utilized since the inception of the IPPS. In addition, the commenter included procedure codes in its analysis that do not identify the insertion of a stent; thereby, the data are unreliable. Furthermore, two procedure codes describing the insertion of a colonic stent were recently implemented, effective with discharges occurring on or after October 1, 2009—procedure code 46.86 (Endoscopic insertion of colonic stent(s)) and procedure code 46.87 (Other insertion of colonic stent(s)). However, we do not have data currently available on these two new procedure codes to include them in a comprehensive analysis. Lastly, as the commenter indicated, the differences between those procedures with and without stents is a reflection on the severity of illness and resource consumption associated with these types of procedures. The commenter also acknowledged that patients receiving a gastrointestinal stent who are severely debilitated due to prolonged illness are reflected by the fact that the majority of cases are assigned to MS–DRGs for patients with MCCs (major complications or comorbidities). Therefore, the medical MS–DRGs to which these procedures are currently assigned already account for the severity of illness and intensity of resources utilized.

Using FY 2009 MedPAR data, we analyzed the three procedure codes that truly identify and describe the insertion of a stent (procedure codes 42.81, 51.87, and 52.93) within the MS–DRGs referenced above. Similar to the commenter's findings, our analysis demonstrated a small volume of cases in which insertion of a gastrointestinal stent occurred in the specified MS–DRGs. Of the 411,390 total cases across the digestive system MS–DRGs the requestor identified, there were only 2,011cases that involved the actual insertion of a gastrointestinal stent. These cases had average costs ranging from a low of $5,846 to a high of $17,626. Based on these findings, we do not believe it is appropriate to assign cases with such disparity in costs into a single, new MS–DRG. Furthermore, in applying the five criteria used to establish new MS–DRGs, the data do not support the creation of new MS–DRGs with three severity levels (with MCC, with CC, and without CC/MCC).

For the reasons stated above, we invite the public to submit comments on our proposal not to make any MS–DRG modifications at this time to cases involving the use of gastrointestinal stents for FY 2011.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Pedicle-Based Dynamic Stabilization

As we did for FY 2009 (73 FR 45820), we received a request from a manufacturer to reassign procedure code 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), effective October 1, 2007, from MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator) to MS–DRG 460

(Spinal Fusion Except Cervical without MCC). According to the manufacturer, the technology that is identified by this procedure code, the Dynesys® Dynamic Stabilization System, is clinically similar to lumbar spinal fusion and requires similar utilization of resources.

Dynamic stabilization is a concept that utilizes a flexible system to stabilize the spine without fusion. The primary goals of dynamic stabilization are to limit the amount of unnatural spinal motion and preserve as much of the patient's natural anatomic structures as possible. The Dynesys® Dynamic Stabilization System is comprised of three components with specific functions: Titanium alloy pedicle screws that anchor the system to the spine; a polyethylene-terephthalate (PET) cord that connects the Dynesys® screws; and a polycarbonate-urethane (PCU) spacer that runs over the cord between the Dynesys® screws. The system is placed under tension creating a dynamic interaction between the components.

The MS–DRGs are comprised of clinically coherent groups of patients who consume similar utilization of resources and complexity of services. The insertion of a Dynesys® Dynamic Stabilization System is clinically not a lumbar fusion. As stated previously, dynamic stabilization is a concept that utilizes a flexible system to stabilize the spine without fusion. Therefore, it would be clinically inappropriate to reassign cases reporting procedure code 84.82 in the fusion MS–DRG.

In conclusion, the Dynesys® Dynamic Stabilization System is currently FDA approved for use only as an adjunct to spinal fusion, there is uncertainty regarding the coding and reporting of procedure code 84.82, as well as off-label use, and currently, all other similar nonfusion devices are assigned to MS–DRG 490.

For the reasons listed above, we are not proposing to reassign cases reporting procedure code 84.82 from MS–DRG 490 to MS–DRG 460 for FY 2011.

6. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

a. Discharges/Transfers of Neonates to a Designated Cancer Center or Children's Hospital

We received a request to add patient discharge status code 05 (Discharged/transferred to a designated cancer center or children's hospital) to the MS–DRG GROUPER logic for MS–DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility). Currently, neonate cases with the discharge status code 05 are being assigned to MS–DRG 795 (Normal Newborn).

The definition of discharge status code 05 was changed on April 1, 2008, from "discharged/transferred to another type of health care institution not defined elsewhere in this code list" to "discharged/transferred to a designated cancer center or children's hospital." We examined cases in the FY 2009 MedPAR file but did not find any cases with the discharge status code 05 that were assigned to either MS–DRG 789 or MS–DRG 795. However, we believe that the request has merit in identifying neonate cases appropriately. Therefore, for FY 2011, we are proposing to add discharge status code 05 to the MS–DRG GROUPER logic for MS–DRG 789.

b. Vaccinations of Newborns

We received a request to examine the assignment of code V64.05 (Vaccination not carried out because of caregiver refusal) to MS–DRG 794 (Neonate with Other Significant Problems). Code V64.05 is currently being reported when a physician documents that a parent/caregiver has refused immunization for a child. The reporting of this code as a principal or secondary diagnosis impacts the MS–DRG assignment for normal newborns cases being assigned to MS–DRG 794.

We examined cases in the FY 2009 MedPAR file but did not find any cases of code V64.05 assigned to MS–DRG 794. Our medical advisors agree that code V64.05 should not be assigned to MS–DRG 794. We determined that the presence of code V64.05 does not indicate that there is a significant problem with the newborn and should not be assigned to MS–DRG 794. Therefore, we believe that assignment of code V64.05 to MS–DRG 795 (Normal Newborn) would be more appropriate for this code because it does not identify a significant problem.

The logic for MS–DRG 795 contains a list of principal diagnosis codes for normal newborn and no secondary diagnosis or a list of only secondary diagnosis codes. Therefore, in this proposed rule, for FY 2011, we are proposing to remove code V64.05 from MS–DRG 794 and add this code to the only secondary diagnosis list for MS–DRG 795.

7. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this proposed rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a MS–DRG. For FY 2011, we intend to make the following changes to the MCE edits and invite public input on whether or not we should do so:

a. Unacceptable Principal Diagnosis Edit: Addition of Code for Gastroparesis

It has been brought to our attention that code 536.3 (Gastroparesis) has a "code first underlying disease" note. This note indicates that code 536.3 should not be used as a principal diagnosis. Therefore, code 536.3 should have been included on the list of unacceptable principal diagnoses in the MCE.

We agree that code 536.3 should have been included on the list of unacceptable principal diagnoses in the MCE. Therefore, for FY 2011, we intend to add code 536.3 to that list.

b. Open Biopsy Check Edit

The Open Biopsy Check edit in the MCE dates back to the early years of the IPPS when the surgical and medical DRGs were not as expansive as they are today. In the mid-1980s when the Open Biopsy Check edit was created, the ICD–9–CM codes did not have many biopsy procedure codes that clearly showed the approach, such as codes for open, percutaneous, and closed biopsies. Furthermore, under the current MS–DRGs, the open biopsy codes do not have as significant an impact as they did in the early versions of the DRGs. We believe that the Open Biopsy Check edit no longer serves a useful purpose. Therefore, for FY 2011, we intend to delete the entire Open Biopsy Check edit from the MCE, which means removing the following 63 codes from the edit:

- 01.11 (Closed [Percutaneous] [Needle] biopsy of cerebral meninges)
- 01.12 (Open biopsy of cerebral meninges)
- 01.13 (Closed [Percutaneous] [Needle] biopsy of brain)
- 01.14 (Open biopsy of brain)
- 04.11 (Closed [Percutaneous] [Needle] biopsy of cranial or peripheral nerve or ganglion)
- 04.12 (Open biopsy of cranial or peripheral nerve or ganglion)
- 06.11 (Closed [Percutaneous] [Needle] biopsy of thyroid gland)
- 06.12 (Open biopsy of thyroid gland)
- 07.11 (Closed [Percutaneous] [Needle] biopsy of adrenal gland)
- 07.12 (Open biopsy of adrenal gland)

- 22.11 (Closed [Endoscopic] [Needle] biopsy of nasal sinus)
- 22.12 (Open biopsy of nasal sinus)
- 25.01 (Closed [Needle] biopsy of tongue)
- 25.02 (Open biopsy of tongue)
- 26.11 (Closed [Needle] biopsy of salivary gland or duct)
- 26.12 (Open biopsy of salivary gland or duct)
- 31.43 (Closed [Endoscopic] biopsy of larynx)
- 31.44 (Closed [Endoscopic] biopsy of trachea)
- 31.45 (Open biopsy of larynx or trachea)
- 33.24 (Closed [Endoscopic] biopsy of bronchus)
- 33.25 (Open biopsy of bronchus)
- 33.26 (Closed [Percutaneous] [Needle] biopsy of lung)
- 33.28 (Open biopsy of lung)
- 34.25 (Closed [Percutaneous] [Needle] biopsy of mediastinum)
- 34.26 (Open mediastinal biopsy)
- 41.32 (Closed [Aspiration] [Percutaneous] biopsy of spleen)
- 41.33 (Open biopsy of spleen)
- 42.24 (Closed [Endoscopic] biopsy of esophagus)
- 42.25 (Open biopsy of esophagus)
- 44.14 (Closed [Endoscopic] biopsy of stomach)
- 44.15 (Open biopsy of stomach)
- 45.14 (Closed [Endoscopic] biopsy of small intestine)
- 45.15 (Open biopsy of small intestine)
- 45.25 (Closed [Endoscopic] biopsy of large intestine)
- 45.26 (Open biopsy of large intestine)
- 48.24 (Closed [Endoscopic] biopsy of rectum)
- 48.25 (Open biopsy of rectum)
- 50.11 (Closed (Percutaneous) [Needle] biopsy of liver)
- 50.12 (Open biopsy of liver)
- 51.12 (Percutaneous biopsy of gallbladder or bile ducts)
- 51.13 (Open biopsy of gallbladder or bile ducts)
- 52.11 (Closed [Aspiration] [Needle] [Percutaneous] biopsy of pancreas)
- 52.12 (Open biopsy of pancreas)
- 54.23 (Biopsy of peritoneum)
- 54.24 (Closed [Percutaneous] [Needle] biopsy of intra-abdominal mass)
- 55.23 (Closed [Percutaneous] [Needle] biopsy of kidney)
- 55.24 (Open biopsy of kidney)
- 56.32 (Closed percutaneous biopsy of ureter)
- 56.34 (Open biopsy of ureter)
- 57.33 (Closed [Transurethral] biopsy of bladder)
- 57.34 (Open biopsy of bladder)
- 60.11 (Closed [Percutaneous] [Needle] biopsy of prostate)
- 60.12 (Open biopsy of prostate)
- 60.13 (Closed [Percutaneous] biopsy of seminal vesicles)
- 60.14 (Open biopsy of seminal vesicles)
- 62.11 (Closed [Percutaneous] [Needle] biopsy of testis)
- 62.12 (Open biopsy of testis)
- 68.13 (Open biopsy of uterus)
- 68.14 (Open biopsy of uterine ligaments)
- 68.15 (Closed biopsy of uterine ligaments)
- 68.16 (Closed biopsy of uterus)
- 85.11 (Closed [Percutaneous] [Needle] biopsy of breast)
- 85.12 (Open biopsy of breast)

c. Noncovered Procedure Edit

The ICD–9–CM procedure codes 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas) alone (that is, without procedure code 55.69 (Other kidney transplantation)) are considered noncovered procedures, except when either one is combined with at least one specific principal or secondary diagnosis code. These specific diagnosis codes identify Type I diabetes mellitus, not stated as uncontrolled, or else identified as uncontrolled.

To conform to the proposed change to Pre-MDC MS–DRGs 008 and 010 as discussed in section II.G.1. of this preamble, in which we are proposing to add code 251.3 (Postsurgical hypoinsulinemia) to those MS–DRGs, we intend to add procedure code 251.3 to the list of acceptable principal or secondary diagnosis codes in the MCE.

8. Surgical Hierarchies

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

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

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

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average cost is ordered above a surgical class with a higher average cost. For example, the "other O.R. procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average costs for the MS–DRG or MS–DRGs in that surgical class may be higher than those for other surgical classes in the MDC. The "other O.R. procedures" class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur

if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

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

Based on the changes that we are proposing for FY 2011, as discussed in section II.C.2 of this preamble, we are proposing to revise the surgical hierarchy for Pre-MDCs and MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) to reflect the resource intensiveness of the MS–DRGs, as follows:

In Pre-MDCs, we are proposing to reorder proposed new MS–DRG 014 (Allogeneic Bone Marrow Transplant) above MS–DRG 007 (Lung Transplant); and proposed new MS–DRG 015 (Autologous Bone Marrow Transplant) above MS–DRG 010 (Pancreas Transplant).

In MDC 10, we are proposing to reorder MS–DRG 614 (Adrenal and Pituitary Procedures With CC/MCC) and MS–DRG 615 (Adrenal and Pituitary Procedures Without CC/MCC) above MS–DRG 625 (Thyroid, Parathyroid and Thyroglossal Procedures With MCC).

9. Complications or Comorbidity (CC) Exclusions List

a. Background

As indicated earlier in the preamble of this proposed rule, under the IPPS MS–DRG classification system, we have developed a standard list of diagnoses that are considered CCs. Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2. and 3. of the preamble of the FY 2008 IPPS final rule with comment period for a discussion of the refinement of CCs in relation to the MS–DRGs we adopted for FY 2008 (72 FR 47121 through 47152).

b. Proposed CC Exclusions List for FY 2011

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

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

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

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

(1) Proposed Limited Revisions Based on Changes to the ICD–9–CM Diagnosis Codes

For FY 2011, we are proposing to make limited revisions to the CC Exclusions List for FY 2011 to take into account the changes made in the ICD–9–CM diagnosis coding system effective October 1, 2009. (We refer readers to section II.G.11. of the preamble of this proposed rule for a discussion of ICD–9–CM changes.) We are proposing to make these changes in accordance with the principles established when we created the CC Exclusions List in 1987. In addition, we are indicating on the CC Exclusions List some changes as a result of updates to the ICD–9–CM codes to reflect the exclusion of codes from being MCCs under the MS–DRG system that we adopted in FY 2008.

(2) Suggested Changes to Severity Levels for Obesity-Related and Major Osseous Defect Diagnosis Codes

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43793 through 43794), we indicated that several commenters on the FY 2010 IPPS proposed rule recommended that CMS consider making further adjustments to the MS–DRG assignments based on obesity and major osseous defects. The commenters stated that obesity, high Body Mass Index (BMI) ratings, and major osseous defects add to the complexity of care for patients such as those patients undergoing orthopedic procedures. The commenters recommended the following changes to the list of MCCs and CCs:

Several commenters recommended that CMS add the following diagnosis codes, which are classified as non-CCs, to the CC or MCC list:

[2] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; the FY 2007 final rule (71 FR 47870) for the FY 2007 revisions; the FY 2008 final rule (72 FR 47130) for the FY 2008 revisions, the FY 2009 final rule (73 FR 48510), and the FY 2010 final rule (74 FR 43799). In the FY 2000 final rule (64 FR 41490, July 30, 1999, we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

- 731.3 (Major osseous defects)
- V85.35 (Body mass index 35.0–35.9, adult)
- V85.36 (Body mass index 36.0–36.9, adult)
- V85.37 (Body mass index 37.0–37.9, adult)
- V85.38 (Body mass index 38.0–38.9, adult)
- V85.39 (Body mass index 39.0–39.9, adult)

Several commenters recommended that CMS add the following diagnosis code, which is on the CC list, to the MCC list:

- V85.40 (Body mass index 40 and over, adult)

We stated that we believed these comments were outside the scope of the proposal in the proposed rule. We did not propose significant revisions to the MS–DRGs in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24091) for these codes. We stated that we were encouraging individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, we did not add these codes to the MCC list or the CC list for FY 2010. We stated that we would consider their appropriateness for inclusion in next year's annual proposed rule.

In addition to the diagnosis codes mentioned above, we also have received requests that we consider changing the following diagnosis codes from a non-CC to a CC:

- 278.00 (Obesity NOS)
- 278.01 (Morbid obesity)
- 278.02 (Overweight)

We analyzed claims data for the diagnosis codes mentioned above related to obesity and major osseous defects. We used the same approach we used in initially creating the MS–DRGs and classifying secondary diagnosis codes as non-CCs, CCs, or MCC. A detailed discussion of the process and criteria we used in this process is described in the FY 2008 IPPS final rule (72 FR 47158 through 47161). We refer the readers to this discussion for complete information on our approach to developing the non-CC, CC, and MCC lists. Each diagnosis for which Medicare data were available was evaluated to determine its impact on resource use and to determine the most appropriate CC subclass (non-CC, CC, or MCC) assignment. In order to make this determination, the average cost for each subset of cases was compared to the expected cost for cases in that subset. The following format was used to evaluate each diagnosis:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3

Count (Cnt) is the number of patients in each subset. C1, C2, and C3 are a measure of the impact on resource use of patients in each of the subsets. The C1, C2, and C3 values are a measure of the ratio of average costs for patients with these conditions to the expected average cost across all cases. The C1 value reflects a patient with no other secondary diagnosis or with all other secondary diagnoses that are non-CCs. The C2 value reflects a patient with at least one other secondary diagnosis that is a CC but none that is a MCC. The C3 value reflects a patient with at least one other secondary diagnosis that is a MCC. A value close to 1.0 in the C1 field would suggest that the diagnosis code produces the same expected value as a non-CC. A value close to 2.0 suggests the condition is more like a CC than a non-CC but not as significant in resource usage as an MCC. A value close to 3.0 suggests the condition is expected to consume resources more similar to an MCC than a CC or non-CC. For additional details on this analysis, we refer readers to the FY 2008 IPPS final rule at 72 FR 47158 through 47161.

The following chart shows the analysis for each of the obesity related and major osseous defect diagnosis codes that are currently classified as non-CCs.

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
278.00	Obesity NOS	130,310	1.0755	116,304	1.7234	45,565	2.3843
278.01	Morbid obesity	51,832	1.2619	106,169	1.9630	52,398	2.6787
278.02	Overweight	5,242	0.9948	3,594	1.7042	1,033	2.3471
731.3	Major osseous defects	215	1.3833	575	2.3390	186	2.7627
V85.35	BMI 35.0–35.9, adult	2,621	0.9759	1,480	1.6932	499	2.3664
V85.36	BMI 36.0–36.9, adult	2,359	0.9729	1,298	1.6536	466	2.3107
V85.37	BMI 37.0–37.9, adult	2,305	0.9849	1,271	1.7225	473	2.4032
V85.38	BMI 38.0–38.9, adult	2,152	0.9713	1,231	1.5964	432	2.2743
V85.39	BMI 39.0–39.9, adult	2,253	0.9857	1,141	1.7741	445	2.4919

The C1 findings do not support a reclassification of any of these diagnosis codes from a non-CC to a CC. As can be seen by the C1 findings, the codes range from a low of 0.9729 for code V85.35 to a high of 1.3833 for diagnosis code 731.3. These findings are consistent with a classification as a non-CC. Therefore, for FY 2011, we are not proposing to change the CC classification of any of the diagnosis codes mentioned in the chart above from a non-CC to a CC. Our clinical advisors agree with this recommendation.

We also examined claims data for diagnosis code V85.4 (Body mass index 40 and over, adult), which is classified as a CC. We received a request to reclassify this code as a MCC. The following chart summaries our findings for this diagnosis code:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
V85.4	BMI 40 and over, adult	51,871	1.2323	59,941	2.1711	57,220	3.0465

We note that the C1 finding of 1.2323 does not support a reclassification of this diagnosis code from a CC to a MCC. This finding is much more consistent with classifying the code as a non-CC. Our clinical advisors recommended that CMS not reclassify this diagnosis code from a CC to a non-CC at this time. They recommended that CMS analyze data associated with this diagnosis code again in the future to determine if it continues to act like a non-CC. We are not recommending any change in the severity classification of diagnosis code V85.4. We are proposing to retain it as a CC for FY 2011.

We welcome public comments on our proposal not to change the severity levels of the diagnosis codes mentioned above.

(3) Suggested Change to the Severity Level for Alzheimer's Disease Diagnosis Code

We received a request to change the severity classification for diagnosis code 331.0 (Alzheimer's disease). Currently, this diagnosis code is classified as a non-CC. We analyzed claims data for this diagnosis code. The following chart shows our findings:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
331.0	Alzheimer's disease	83,743	1.1381	114,445	1.8890	77,841	2.4185

The C1 finding of 1.1381 for Alzheimer's disease supports the current classification of this diagnosis code as a non-CC. Our clinical advisors agree with this classification. Therefore, we are not proposing to change the severity classification of diagnosis code 331.0 from a non-CC to a CC for FY 2011. We believe the code is appropriately classified as a non-CC.

(4) Proposed Change to the Severity Level for Acute Renal Failure, Unspecified Diagnosis Code

We received a request to reclassify diagnosis code 584.9 (Acute renal failure, unspecified) from a MCC to a CC. The commenter stated that this code is being widely used to capture degrees of renal failure that range from that which is caused by mild dehydration with only minor laboratory abnormalities all the way through severe renal failure that requires dialysis. The commenter pointed out that there are no clinical criteria for assigning diagnosis code 584.9 (Acute renal failure, unspecified). The attending physician must simply document the presence of acute renal failure for the diagnosis code to be assigned. The concern is that the diagnosis code for Acute renal failure, unspecified (diagnosis code 584.9) is being assigned to patients with a low clinical severity level.

We also point out that the Editorial Advisory Board of Coding Clinic for ICD–9–CM has received a number of requests to clarify the use of diagnosis code 584.9. Coders are observing the terminology of "acute renal failure" being applied to patients who are simply dehydrated. These patients do not require renal dialysis, and they do not appear to be severely ill. Coders have stated that there appears to be an increase in the use of the terminology of acute renal failure for patients who were previously referred to as acute renal insufficiency. When acute renal insufficiency is documented, the ICD–9–CM index directs the use of code 593.9 (Unspecified disorder of kidney and ureter). Diagnosis code 593.9 includes acute renal insufficiency and is classified as a non-CC. The problem is further compounded by the fact that there is no consistent convention among clinicians for documenting acute renal insufficiency versus acute renal failure.

We examined claims data on diagnosis code 584.9, and our findings are shown in the table below:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
584.9	Acute kidney failure, unspecified	124,428	1.8364	411,667	2.6151	417,359	3.2429

The C1 finding of 1.8364 is more consistent with a classification of a CC. Our clinical advisors agreed that cases captured by diagnosis code 584.9 are more appropriately classified as a CC. This unspecified type of kidney failure is clearly not capturing patients with a MCC severity level. Therefore, we are proposing to change the severity level for diagnosis code 584.9 from a MCC to a CC for FY 2011.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which are effective for discharges occurring on or after October 1, 2010, are not being published in the Addendum to this proposed rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H in the Addendum to this proposed rule with an asterisk, and the conditions that will not count as a CC, are provided in an indented column immediately following the affected principal diagnosis.

A complete updated MCC, CC, and Non-CC Exclusions List is also available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* Beginning with discharges on or after October 1, 2010, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

There were no additions to the MS–DRG MCC List for FY 2011 (Table 6I.1).

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

Code	Description
584.9	Acute renal failure, unspecified

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

Code	Description
584.9	Acute renal failure, unspecified
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
786.39	Other hemoptysis
999.60	ABO incompatibility reaction, unspecified
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.62	ABO incompatibility with acute hemolytic transfusion reaction
999.63	ABO incompatibility with delayed hemolytic transfusion reaction
999.69	Other ABO incompatibility reaction
999.70	Rh incompatibility reaction, unspecified
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.72	Rh incompatibility with acute hemolytic transfusion reaction
999.73	Rh incompatibility with delayed hemolytic transfusion reaction
999.74	Other Rh incompatibility reaction
999.75	Non-ABO incompatibility reaction, unspecified
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction
999.79	Other non-ABO incompatibility reaction
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult

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

Code	Description
786.3	Hemoptysis
999.6	ABO incompatibility reaction
999.7	Rh incompatibility reaction
V85.4	Body Mass Index 40 and over, adult

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Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current MS–DRG Definitions Manual, Version 27.0, is available for $250.00, which includes shipping and handling. Version 27.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. Version 28.0 of this manual, which will include the final FY 2011 MS–DRG changes, will be available on CD only for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303, or by obtaining an order form at the Web site: *http://www.3MHIS.com*. Please specify the revision or revisions requested.

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

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

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

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

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

Our review of MedPAR claims data showed that there were 59 cases in which procedures related to the prostate were arrayed across 10 different MDCs. None of the 59 cases were cases that should logically be assigned to any of the other MDCs. For example, there were a total of 16 cases of other transurethral prostate surgery that occurred in MDC 5 (Diseases and Disorders of the Circulatory System). In addition, none of the cases had lengths of stay or average charges that would indicate that these cases were anything other than some of the expected irregularities of medical care. Therefore, for FY 2011, we are not proposing to change the procedures assigned among these MS–DRGs.

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

We annually conduct a review of procedures producing assignment to MS–DRGs 981 through 983 (Extensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC, respectively) or MS–DRGs 987 through 989 (Nonextensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC, respectively) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these MS–DRGs into one of the surgical MS–DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical MS–DRGs for the MDC in which the diagnosis falls. Our review of claims data showed that there were 4,443 cases in MS–DRGs 981 through 983. These 4,443 cases were arrayed across 18 MDCs. The single most common procedure was code 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] of coronary atherectomy), 21 cases, located in MDC 1 (Diseases and Disorders of the Nervous System). These cases represent a very small volume of cases that are unlikely to indicate medical practice trends. In addition, from a clinical coherence standpoint, we do not believe it benefits the GROUPER system to add cardiac procedures to the nervous system MDC. The same situation was evident in MS–DRGs 987 through 989. There were a total of 1,601 cases across 17 MDCs and, again, the cases did not

[3] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554. In FYs 2008, 2009, and FY 2010, no procedures were moved, as noted in the FY 2008 final rule with comment period (72 FR 46241), the FY 2009 final rule (73 FR 48513), and the FY 2010 final rule (74 FR 43796).

represent clinically coherent examples of medical care that warranted movement of procedure codes into additional MS–DRGs. Examples of cases that we reviewed included six cases of bone biopsies in MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs) and one case of a destruction of a lesion of the knee in MDC 13 (Diseases and Disorders of the Female Reproductive System). Again, the volume of these cases is negligible, and clinical coherence is not demonstrated to the degree that a change in the MS–DRGs is warranted. Therefore, for FY 2011, we are not proposing to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989 into one of the surgical MS–DRGs for the MDC into which the principal diagnosis is assigned.

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

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to MS–DRGs 981 through 983, 984 through 986 (Prostatic O.R. procedure unrelated to principal diagnosis with MCC, with CC, or without CC/MCC, respectively), and 987 through 989, to ascertain whether any of those procedures should be reassigned from one of these three MS–DRGs to another of the three MS–DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting MS–DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the MS–DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

To reiterate, our review of claims data showed that 18 MDCs were represented in MS–DRGs 981 through 983, for a total of 4,443 cases. There were 10 MDCs represented in MS–DRGs 984 through 986, which contained 59 cases. In addition, our review of claims data for MS–DRGs 987 through 989 showed 1,601 cases across 17 MDCs. However, these cases represent such disparate situations as one case of a large bowel incision assigned to MDC 1 (Diseases and Disorders of the Nervous System) and one case of a revision of the femoral component of a hip replacement assigned to MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). We do not believe that any of these cases represent shifts in either treatment practice or reporting practice. As these types of cases do not represent clinical coherence, we do not believe that the addition of these procedure codes identified in our review would positively benefit the overall MS–DRG logic. Therefore, for FY 2011, we are not proposing to move any procedure codes among these MS–DRGs.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on the review of cases in the MDCs as described above in sections G.10.a. and b., we are not proposing to add any diagnosis or procedure codes to MDCs for FY 2011.

11. Changes to the ICD–9–CM Coding System, Including Discussion of the Replacement of the ICD–9–CM Coding System With the ICD–10–CM and ICD–10–PCS Systems in FY 2014

a. ICD–9–CM Coding System

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

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

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

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

The Committee presented proposals for coding changes for implementation in FY 2011 at a public meeting held on September 16–17, 2009 and finalized the coding changes after consideration of comments received at the meetings and in writing by November 20, 2009. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. The Committee held its 2010 meeting on March 9–10, 2010. New codes for which there was a consensus of public support and for which complete tabular and indexing changes are made by May 2010 will be included in the October 1, 2010 update to ICD–9–CM. Code revisions that were discussed at the March 9–10, 2010 Committee meeting but that could not be finalized in time to include them in the Addendum to this proposed rule will be included in Tables 6A through 6F of the final rule and will be marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 16–17, 2009 meeting and March 9–10, 2010 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* The minutes of the diagnosis codes discussions at the September 16–17, 2009 meeting and March 9–10, 2010 meeting are found at: *http://www.cdc.gov/nchs/icd.htm.* These Web sites also provide detailed

information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

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

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

The ICD–9–CM code changes that have been approved will become effective October 1, 2010. The new ICD–9–CM codes are listed, along with their MS–DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

In this proposed rule, we are soliciting comments on the proposed classification of these new codes, which are shown in Tables 6A and 6B of the Addendum to this proposed rule.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A in the Addendum to this proposed rule. New procedure codes are shown in Table 6B in the Addendum to this proposed rule. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes) in the Addendum to this proposed rule. These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2010. Table 6D in the Addendum to this proposed rule contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2010. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles) in the Addendum to this proposed rule, which also includes the MS–DRG assignments for these revised codes. Table 6F in the Addendum to this proposed rule includes revised procedure code titles for FY 2011.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 9–10, 2010 Committee meeting that receive consensus and that are finalized by May 2010 will be included in Tables 6A through 6F in the Addendum to the final rule.

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

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

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

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

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at

the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April 1, 2010 implementation of an ICD–9–CM code at the September 16–17, 2009 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2010.

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

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

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

b. Code Freeze

The International Classification of Diseases, 10th Revision (ICD–10) coding system applicable to hospital inpatient services will be implemented on October 1, 2013, as described in the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Modifications to Medical Data code Set Standards to Adopt ICD–10–CM and ICD–10–PCS final rule (74 FR 3328 through 3362, January 16, 2009). The ICD–10 coding system includes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding, as well as the Official ICD–10–CM and ICM–10–PCS Guidelines for Coding and Reporting. In the January 16, 2009 ICD–10–CM and ICD–10–PCS final rule (74 FR 3328 through 3362), there was a discussion of the need for a partial or total freeze in the annual updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes. The public comment addressed in this final rule stated that the annual code set updates should cease l year prior to the implementation of ICD–10. The commenters stated that this freeze of code updates would allow for instructional and/or coding software programs to be designed and purchased early, without concern that an upgrade would take place immediately before the compliance date, necessitating additional updates and purchases.

We responded to comments in the ICD–10 final rule that the ICD–9–CM Coordination and Maintenance Committee has jurisdiction over any action impacting the ICD–9–CM and ICD–10 code sets. Therefore, the issue of consideration of a moratorium on updates to the ICD–9–CM, ICD–10–CM, and ICD–10–PCS code sets in anticipation of the adoption of ICD–10–CM and ICD–10–PCS would be addressed through the Committee at a future public meeting.

At the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting, the public was notified that there would be a discussion of whether there was a need to freeze updates to ICD–9–CM and/or ICD–10–CM and ICD–10–PCS prior to the implementation of ICD–10. The audience was asked to consider this issue and be prepared to discuss the topic at the September 16–17, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. Advance written comments on this topic were welcomed. The first part of the meeting was devoted to this topic.

CMS received comments in advance of the meeting. CMS staff summarized these advanced comments at the meeting as follows:

No ICD–9–CM or ICD–10–CM/PCS updates beginning October 1, 2010 (36 months for implementation activities without annual code updates). This approach involves updating ICD–9–CM and ICD–10 codes on October 1, 2010, and not updating them again until after ICD–10 implementation on October 1, 2013. The commenters mentioned the extensive work needed to prepare for the transition to ICD–10 which will affect vendors, payers, providers, trainers, clearinghouses, and all claims handling organizations. The commenters stated that the 36 months between the last ICD–9–CM and ICD–10 updates on October 1, 2010 and the implementation of ICD–10 on October 1, 2013, were necessary to prepare and train for the transition.

No ICD–9–CM or ICD–10–CM/PCS updates beginning October 1, 2011 (24 months for implementation activities without annual code updates). This approach involves updating ICD–9–CM and ICD–10 codes on October 1, 2011, and not updating them again until after ICD–10 implementation on October 1, 2013. The commenters raised similar concerns to those mentioned above. The commenters stated that, if codes continue to change, the changes would make it difficult for vendors, payers, and providers to be ready and for coder training to be successful. One commenter suggested that a provision be developed to perform limited annual updates to capture new technologies or new diagnoses.

No ICD–10–CM/PCS updates beginning October 1, 2012 but continue annual updates to ICD–9–CM. This commenter supported annual updates to ICD–9–CM to capture advances in medical science. However, the commenter supported a freeze of ICD–10 beginning October 1, 2012, to give the industry time to update systems and prepare for ICD–10 implementation.

No ICD–10 updates on October 1, 2012, but update ICD–9–CM without interruption. (No period for implementation activities without annual code updates.) The commenter recommended no ICD–10 updates on October 1, 2012, but then updating ICD–10 again on October 1, 2013. The commenter recommended updating ICD–9–CM continuously through a final update on October 1, 2012. The commenter stated that having a two or three year gap between updating the

code books would lead to a loss of data. The commenter stated that there is a need to retain the ability to update the code books to capture conditions such as Swine flu.

Update both ICD–9–CM and ICD–10–CM/PCS annually through October 1, 2013 (no period for implementation activities without annual code updates). The commenter stated that codes should not be frozen prior to the implementation of ICD–10. The commenter stated that freezing the updates would inhibit the recognition of new technologies.

Many of the commenters suggested a resumption of updates to ICD–10–CM and ICD–10–PCS beginning on October 1, 2014. However, one commenter suggested annual updates of ICD–10–CM and ICD–10–PCS without interruptions, including on October 1, 2013.

The topic was then opened for public discussion at the Committee meeting. CMS received a variety of comments from the participants that mirrored the advance written comments. These comments ranged from those supporting a complete freeze for both coding systems to those who recommended that both coding systems continue to be updated annually prior to ICD–10 implementation. There were also many comments that supported a more limited update process beginning on October 1, 2011, or October 1, 2012, which would allow only a small number of new codes to capture new technologies or new diseases. A number of commenters pointed out that section 503(a) of Public Law 108–173 included a requirement for updating ICD–9–CM codes twice a year to capture new technologies. The commenters stated that CMS must make a provision to capture new technologies despite any requests to freeze code updates.

Commenters voiced concerns about the impact on vendors creating new ICD–10 products when both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes were extensively updated on an annual basis. Commenters stated that vendors and educators were reluctant to begin ICD–10 products and training materials until there was a period of stability without extensive annual updates. Some commenters stated that it was important for physician offices to have time to prepare for the implementation of ICD–10. Reducing the annual ICD–9–CM and ICD–10 annual updates would be helpful to physician offices.

Other commenters stated that it was important to update codes annually so that information on new diseases and technologies can be captured. These commenters stated that vendors, providers, system maintainers, and coders were used to annual code updates, and that they should continue.

One commenter requested that ICD–10–CM codes be frozen on October 1, 2011 so that ICD–10–CM codes could be coordinated with the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition. The commenter stated that the American Psychiatric Association plans to publish the fifth edition in 2012. Updates to ICD–10–CM on or after October 1, 2011, would disrupt those plans.

One commenter suggested an approach that would greatly reduce the number of updates and provide more stability in the coding systems during the implementation period. This commenter suggested that the large, regular code updates on ICD–9–CM be discontinued beginning on October 1, 2011, or October 1, 2012. The commenter suggested that CMS and CDC raise the bar for new code requests at that time and only consider requests for new codes that clearly describe a new technology or a new disease. The commenter stated that this may lead to the creation of some new procedure codes which do not ultimately receive FDA approval, as is the case now.

CMS and CDC have carefully reviewed the comments received at the ICD–9–CM Coordination and Maintenance Committee meeting as well as the written comments submitted. Most commenters proposed a limited freeze on code updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS code sets, with an exception made for adding codes for new technologies and diseases. Providing this exception would comply with section 503(a) of Public Law 108–173, which, as previously stated, includes a requirement for updating ICD–9–CM codes twice a year to capture new technologies. There was support for making the last regular update on October 1, 2011. The commenters recommended that the ICD–9–CM Coordination and Maintenance Committee continue to discuss any new code updates for both coding systems. However, new codes would only be added to ICD–9–CM or ICD–10 to capture new technologies, as required by section 503(a) of Public Law 108–173. Other coding issues raised would be held for consideration after ICD–10 is implemented.

In this proposed rule, we are soliciting additional input on this subject, especially in light of the requirements on hospitals for meaningful use of electronic health records. We welcome public comments that explore whether a freeze is needed to help with adoption of health IT, given other priorities such as achievement of meaningful use and implementation of ICD–10 by FY 2013. We welcome input on having the last regular, annual update to both ICD–9–CM and ICD–10 be made on October 1, 2011. On October 1, 2012, there would be only limited code updates to both the ICD–9–CM and ICD–10 coding systems to capture new technologies and diseases. On October 1, 2013, there would be only limited code updates to ICD–10 to capture new technologies and diagnoses. Any other issues raised would be considered for implementation in ICD 10 on October 1, 2014, a year after ICD–10 is implemented. We agree with commenters that there is a need to provide the provider, payer, and vendor community time to prepare for the implementation of ICD–10 and the accompanying system and product updates. The vendor community is especially interested in providing a more stable code set for ICD–10 while they are developing new products.

We believe that this advance notice of a partial code freeze would provide the health care industry ample time to request last major code updates to ICD–9–CM and ICD–10, which could be discussed at the September 15–16, 2010 and the March 2011 ICD–9–CM Coordination and Maintenance Committee meeting. Codes discussed at these two meetings would be considered for the final major code updates on October 1, 2011. Any code issues raised after that time would be addressed at the ICD–9–CM Coordination and Maintenance Committee meetings in September 2011 through March 2013 to determine if they represented new technologies or new diseases. Any new technologies and diseases would be added during the regular annual updates. Other code requests would be held for implementation on October 1, 2014.

We welcome additional input on having the last regular code updates to ICD–9–CM and ICD–10 on October 1, 2011, and to only add codes for new technologies and diseases on October 1, 2012 and 2013. We also welcome additional input on having the next regular update to ICD–10 occur again on October 1, 2014.

Information on ICD–10 can be found on the CMS Web site at: *http://www.cms.hhs.gov/ICD10*. The final ICD–10 version of MS–DRGs would be adopted under the formal rulemaking process as part of our annual IPPS updates.

c. Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims

We have received repeated requests from the hospital community to process all 25 diagnosis codes and 25 procedure codes submitted on electronic hospital inpatient claims. Hospitals can submit up to 25 diagnoses and 25 procedures; however, CMS' current system limitations allow for the processing of only the first 9 diagnoses and 6 procedures. While CMS accepts all 25 diagnoses and 25 procedures submitted on the claims, we do not process all of the codes because of these system limitations. We recognize that much valuable information is lost by not processing the additional diagnosis and procedure codes that are reported by hospitals.

We responded to hospitals' requests that we process up to 25 diagnosis codes and 25 procedure codes in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43798). In that final rule, we referred readers to the ICD–10 final rule (74 FR 3328 through 3362) where we discuss the updating of Medicare systems prior to the implementation of ICD–10 on October 1, 2013. We mentioned that part of the system updates in preparation for ICD–10 is the "expansion of our ability to process more diagnosis and procedure codes." In the FY 2009 IPPS final rule (73 FR 48433 through 48444), we also responded to multiple requests to increase the number of codes processed from 9 diagnosis and 6 procedure codes to 25 diagnosis and 25 procedure codes.

CMS is currently undergoing extensive system updates as part of the move to 5010, which includes the ability to accept ICD–10 codes. This complicated transition involves converting many internal systems prior to October 1, 2013, when ICD–10 will be implemented. One important step in this planned conversion process is the expansion of our ability to process additional diagnosis and procedure codes. We are currently planning to complete the expansion of this internal system capability so that we are able to process up to 25 diagnoses and 25 procedures on hospital inpatient claims as part of the HIPPA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update. CMS will be able to process up to 25 diagnosis codes and 25 procedure codes when received on the 5010 format starting on January 1, 2011. We recognize the value of the additional information provided by this coded data for multiple uses such as for payment, quality measures, outcome analysis, and other important uses. We will continue to pursue this additional processing capacity as aggressively as possible in response to the multiple requests from the hospital industry. We appreciate the support of the health care community for this extensive system update process that will allow us to process more of this important data. Therefore, for claims submitted on the 5010 format beginning January 1, 2011, we will increase the capacity to process diagnosis and procedure codes on hospital inpatient claims from the current 9 diagnoses and 6 procedures up to 25 diagnoses and 25 procedures.

H. Recalibration of MS–DRG Weights

In developing the proposed FY 2011 system of weights, we used two data sources: Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2009 MedPAR data used in this proposed rule include discharges occurring on October 1, 2008, through September 30, 2009, based on bills received by CMS through December 31, 2009, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2009 MedPAR file used in calculating the proposed relative weights includes data for approximately 11,004,046 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2008 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2007, and before October 1, 2008), which represents the most recent full set of cost report data available. We used the December 31, 2009 update of the HCRIS cost report files for FY 2008 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2009 MedPAR claims data and FY 2008 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the proposed FY 2011 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this proposed rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2009 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each MS–DRG and before eliminating statistical outliers.
- Claims with total charges or total lengths of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.
- At least 96.1 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each MS–DRG.
- Effective October 1, 2008, because hospital inpatient claims include a POA indicator field for each diagnosis present on the claim, only for purposes of relative weight-setting, the POA indicator field was reset to "Y" for "Yes" for all claims that otherwise have an "N" (No) or a "U" (documentation insufficient to determine if the condition was present at the time of inpatient admission) in the POA field.

Under current payment policy, the presence of specific HAC codes, as indicated by the POA field values, can generate a lower payment for the claim.

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

To avoid these problems, we reset the POA indicator field to "Y" only for relative weight-setting purposes for all claims that otherwise have a "N" or an "U" in the POA field. This resetting "forced" the more costly HAC claims into the higher severity MS–DRGs as appropriate, and the relative weights calculated for each MS–DRG more closely reflect the true costs of those cases.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 15 cost groups for each claim were standardized to remove the effects of differences in area wage levels, IME and DSH payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Because hospital charges include charges for both operating and capital costs, we standardized total charges to remove the effects of differences in geographic adjustment factors, cost-of-living adjustments, and DSH payments under the capital IPPS as well. Charges were then summed by MS–DRG for each of the 15 cost groups so that each MS–DRG had 15 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2008 cost report data.

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

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

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

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

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

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

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
				Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
						C_1_C7_60	
	Ambulance Charges	054X					
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
						C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X		Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_62 01
						C_1_C7_6201	
				Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_63 50
	Professional Fees Charges	096X, 097X, and 098X				C_1_C7_6350	
				FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_63 60
						C_1_C7_6360	
				Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
						C_1_C7_64	
				Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65
						C_1_C7_65	

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

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We developed the national average CCRs as follows:

Taking the FY 2008 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D–4 and deriving the Medicare-specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D–4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

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

The new cost-based relative weights were then normalized by an adjustment factor of 1.57461 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

The 15 proposed national average CCRs for FY 2011 are as follows:

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

Since FY 2009, the relative weights have been based on 100 percent cost weights based on our MS–DRG grouping system.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In this FY 2011 proposed rule, we are proposing to use that same case threshold in recalibrating the MS–DRG weights for FY 2011. Using the FY 2009 MedPAR data set, there are 8 MS–DRGs that contain fewer than 10 cases. Under the MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. Newborns are unique and require separate MS–DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate MS–DRGs for newborns. All of the low-volume MS–DRGs listed below are for newborns. In FY 2011, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume MS–DRGs, we are proposing to compute weights for the low-volume MS–DRGs by adjusting their FY 2010 weights by the percentage change in the average weight of the cases in other MS–DRGs. The crosswalk table is shown below:

Low-Volume MS–DRG	MS–DRG title	Crosswalk to MS–DRG
768	Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C.	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
789	Neonates, Died or Transferred to Another Acute Care Facility	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
791	Prematurity with Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
792	Prematurity without Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
793	Full-Term Neonate with Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
794	Neonate with Other Significant Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
795	Normal Newborn	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).

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

1. Background

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

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

Under the first criterion, as reflected in 42 CFR 412.87(b)(2), a specific medical service or technology will be considered "new" for purposes of new medical service or technology add-on payments until such time as Medicare data are available to fully reflect the cost of the technology in the MS–DRG weights through recalibration. Typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the MS–DRG weights. For example, data from discharges occurring during FY 2009 are used to calculate the proposed FY 2011 MS–DRG weights in this proposed rule. Section 412.87(b)(2) of the regulations therefore provides that "a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the MS–DRGs, based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section."

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

We do not consider a service or technology to be new if it is substantially similar to one or more existing technologies. That is, even if a technology receives a new FDA approval, it may not necessarily be considered "new" for purposes of new technology add-on payments if it is "substantially similar" to a technology that was approved by FDA and has been on the market for more than 2 to 3 years. In the FY 2006 IPPS final rule (70 FR

47351), we explained our policy regarding substantial similarity in detail and its relevance for assessing if the hospital charge data used in the development of the relative weights for the relevant DRGs reflect the costs of the technology. In that final rule, we stated that, for determining substantial similarity, we consider (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome, and (2) whether a product is assigned to the same or a different DRG. We indicated that both of the above criteria should be met in order for a technology to be considered "substantially similar" to an existing technology. However, in that same final rule, we also noted that, due to the complexity of issues regarding the substantial similarity component of the newness criterion, it may be necessary to exercise flexibility when considering whether technologies are substantially similar to one another. Specifically, we stated that we may consider additional factors, depending on the circumstances specific to each application.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43813 and 43814), we noted that the discussion of substantial similarity in the FY 2006 IPPS final rule related to comparing two separate technologies made by different manufacturers. Nevertheless, we stated that the criteria discussed in the FY 2006 IPPS final rule also are relevant when comparing the similarity between a new use and existing uses of the same technology (or a very similar technology manufactured by the same manufacturer). In other words, we stated that it is necessary to establish that the new indication for which the technology has received FDA approval is not substantially similar to that of the prior indication. We explained that such a distinction is necessary to determine the appropriate start date of the newness period in evaluating whether the technology would qualify for add-on payments (that is, the date of the "new" FDA approval or that of the prior approval), or whether the technology could qualify for separate new technology add-on payments under each indication.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43814), we added a third factor of consideration to our analysis of whether a new technology is substantially similar to one or more existing technologies. Specifically, in making a determination of whether a technology is substantially similar to an existing technology, we will consider whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population (74 FR 24130), in addition to considering the already established factors described in the FY 2006 IPPS final rule (that is, (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome; and (2) whether a product is assigned to the same or a different DRG). As we noted in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, if all three components are present and the new use is deemed substantially similar to one or more of the existing uses of the technology (that is beyond the newness period), we would conclude that the technology is not new and, therefore, is not eligible for the new technology add-on payment.

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

However, section 503(b)(1) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide that, beginning in FY 2005, CMS will apply "a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved." (We refer readers to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 that was included in the final rule published in the **Federal Register** on August 27, 2009, contains the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2011 (74 FR 44173). We note that we plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions addressing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and the LTCH PPS. At the time we issue those documents, we plan to update Table 10 that was published in the **Federal Register** on August 27, 2009 and Table 10 in the Addendum to this proposed rule.

In the September 7, 2001 final rule that established the new technology add-on payment regulations (66 FR 46917), we discussed the issue of whether the HIPAA Privacy Rule at 45 CFR Parts 160 and 164 applies to claims information that providers submit with applications for new technology add-on payments. Specifically, we explained that health plans, including Medicare, and providers that conduct certain transactions electronically, including the hospitals that would be receiving payment under the FY 2001 IPPS final rule, are required to comply with the HIPAA Privacy Rule. We further explained how such entities could meet the applicable HIPAA requirements by discussing how the HIPAA Privacy Rule permitted providers to share with health plans information needed to ensure correct payment, if they had obtained consent from the patient to use that patient's data for treatment, payment, or health care operations. We also explained that, because the information to be provided within applications for new technology add-on payment would be needed to ensure correct payment, no additional consent would be required. The HHS Office for Civil Rights has since amended the HIPAA Privacy Rule, but the results remain. The HIPAA Privacy Rule no longer requires covered entities to obtain consent from patients to use or disclose protected health information for treatment, payment, or health care operations, and expressly permits such entities to use or to disclose protected health information for any of these purposes. (We refer readers to 45 CFR 164.502(a)(1)(ii), and 164.506(c)(1) and (c)(3), and the Standards for Privacy of Individually Identifiable Health Information published in the **Federal Register** on August 14, 2002, for a full discussion of changes in consent requirements.)

Under the third criterion, § 412.87(b)(1) of our existing regulations

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

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

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

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

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

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

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

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

The CTI aims to provide useful information on its activities and initiatives to stakeholders, including Medicare beneficiaries, advocates, medical product manufacturers, providers, and health policy experts. Stakeholders with further questions about Medicare's coverage, coding, and payment processes, or who want further guidance about how they can navigate these processes, can contact the CTI at *CTI@cms.hhs.gov* or from the "Contact Us" section of the CTI home page (*http://www.cms.hhs.gov/CouncilonTechInnov/*).

We note that applicants for add-on payments for new medical services or technologies for FY 2012 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate that the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be posted as it becomes available on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2012, the Web

site also will list the tracking forms completed by each applicant.

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

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

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

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2011 prior to publication of this FY 2011 IPPS/RY 2011 LTCH PPS proposed rule, we published a notice in the **Federal Register** on November 27, 2009 (74 FR 62339 through 62342), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 19, 2010. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2011 new medical service and technology add-on payment applications before the publication of this FY 2011 proposed rule.

Approximately 80 individuals registered to attend the town hall meeting in person, while additional individuals listened over an open telephone line. Each of the three FY 2011 applicants presented information on its technology, including a discussion of data reflecting the substantial clinical improvement aspect of the technology. We considered each applicant's presentation made at the town hall meeting, as well as written comments submitted on the applications, in our evaluation of the new technology add-on applications for FY 2011 in this proposed rule.

In response to the published notice and the new technology town hall meeting, we received 11 written comments regarding applications for FY 2011 new technology add-on payments. We summarized these comments or, if applicable, indicated that there were no comments received, at the end of each discussion of the individual applications in this proposed rule.

Comment: One commenter, a medical technology association, recommended that CMS, in its consideration as to whether a new technology meets the substantial clinical improvement criterion, judge a diagnostic device on the basis of a diagnostic outcome (improved diagnosis) rather than a therapeutic outcome, recognizing that earlier and improved detection of disease often leads to improved patient outcomes.

Response: We thank the commenter for its comments on the substantial clinical improvement criterion. Similar to our statements in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43817 through 43819), section 1886(d)(5)(K)(vi) of the Act authorizes the Secretary to establish through notice and comment rulemaking the criteria that a new medical service or technology must meet in order to be eligible for the new technology add-on payment. Under this authority, in the September 7, 2001 final rule, we established three criteria through notice and comment rulemaking—the newness criterion, the cost criterion, and the substantial clinical improvement criterion (66 FR 46924). Specifically, § 412.87(b)(1) of the regulations provides that a new medical service or technology must "represent an advance that substantially improves, relating to technologies previously available, the diagnosis or treatment of Medicare beneficiaries."

As we explained in the September 7, 2001 final rule, we consider a diagnostic technology to meet the substantial clinical improvement criterion if the technology not only "offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods," but also if "use of the device to make a diagnosis affects the management of the patient" (66 FR 46914). We believe that this evidence is necessary to determine whether the new technology affords a "clear improvement over the use of previously available technologies." We do not consider any particular type of evidence to be dispositive; instead, we consider all information presented for each application to determine whether there is evidence to support a conclusion that "use of the device to make a diagnosis affects the management of the patient" (in the case of a diagnostic technology). Specifically, we consider whether the peer-reviewed medical literature supports or clinical studies indicate that the diagnostic device should generally be used by providers in guiding the management of their patients. In addition, we consider evidence demonstrating clinically accepted use of the device in a manner that actually affects the management of patients.

Under the commenter's recommendation, a diagnostic technology effectively would only need to receive FDA approval and be the only technology approved for a particular diagnostic capability in order to be deemed a "substantial improvement" for purposes of new technology add-on payments, regardless of its ability to positively affect patient management. This approach would deem a device that led to the identification of new information as a substantial improvement in diagnosis even if such detection has not been "demonstrated to represent a substantial improvement in caring for Medicare beneficiaries" and was not linked to evidence-based, significant, and positive changes in the management of patients or, ultimately, to changes in clinical outcomes. We do not believe this rationale is consistent with our prior statements regarding the substantial clinical improvement criterion of the new technology add-on payment provision.

Comment: One commenter, a medical device association, recommended that CMS "deem a device to satisfy the substantial clinical improvement criteria if it was granted a humanitarian device exemption or priority review based on the fact that it represents breakthrough technologies, which offer significant advantages over existing approved alternatives, for which no alternatives exist, or the availability of which is in the best interests of the patients." In addition, the commenter

remarked that this process would simplify CMS' evaluation of applications for new technology add-on payments and would promote access to innovative treatments, as intended by Congress. Although the commenter also made remarks that were unrelated to substantial clinical improvement, because the purpose of the town hall meeting was specifically to discuss substantial clinical improvement of pending new technology applications, those comments are not summarized in this proposed rule.

Response: We thank the commenter for its comments. We note that we have previously addressed the comment concerning automatically approving technologies that have a humanitarian device exemption (HDE) in the FY 2008 IPPS final rule (72 FR 47302). We refer readers to that rule for our response. A further discussion of our evaluation of the applications and the documentation for new technology add-on payments submitted for FY 2011 approval is provided under the specified areas under this section.

3. FY 2011 Status of Technologies Approved for FY 2010 Add-On Payments

a. Spiration® IBV® Valve System

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

With regard to the newness criterion, the Spiration® IBV® received an HDE approval from the FDA on October 24, 2008. We were unaware of any previously FDA-approved predicate devices, or otherwise similar devices, that could be considered substantially similar to the Spiration® IBV®. However, the applicant asserted that the FDA had precluded the device from being used in the treatment of any patients until Institutional Review Board (IRB) approvals regarding its study sites. Therefore, the Spiration® IBV® met the newness criterion once it obtained at least one IRB approval because the device would then be available on the market to treat Medicare beneficiaries.

After evaluation of the newness, costs, and substantial clinical improvement criteria for new technology payments for the Spiration® IBV® and consideration of the public comments we received on the FY 2010 IPPS proposed rule, including the additional analysis of clinical data and supporting information submitted by the applicant, we approved the Spiration® IBV® for new technology add-on payments for FY 2010. The Spiration® IBV® is the only device currently approved for the purpose of treating prolonged air leaks following lobectomy, segmentectomy, and LVRS patients in the United States. We stated that without the availability of this device, patients with prolonged air leaks (following lobectomy, segmentectomy, and LVRS) might otherwise remain inpatients in the hospital (and have a longer length of stay than they might otherwise have without the Spiration® IBV®) or might even require additional invasive surgeries to resolve the air leak. We also noted that use of the Spiration® IBV® may lead to more rapid beneficial resolution of prolonged air leaks and reduce recovery time following the three lung surgeries mentioned above.

However, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43823), we indicated that we remained interested in seeing whether the clinical evidence continues to find it to be effective. This approval was on the basis of using the Spiration® IBV® consistent with the FDA approval (HDE), and we emphasized the need for appropriate patient selection accordingly. Therefore, we limited the add-on payment to cases involving prolonged air leaks following lobectomy, segmentectomy and LVRS in MS–DRGs 163, 164, and 165. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment are identified by assignment to MS–DRGs 163, 164, and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that the average cost of the Spiration® IBV® is reported as $2,750. Based on data from the FY 2010 application, the average amount of valves per case is 2.5. Therefore, the total maximum cost for the Spiration® IBV® was expected to be $6,875 per case ($2,750 × 2.5). Under § 412.88(a)(2) of our regulations, new technology add-on payments are limited to the lesser of 50 percent of the average cost of the device or 50 percent of the costs in excess of the MS–DRG payment for the case. As a result, we finalized a maximum add-on payment for a case involving the Spiration® IBV® as $3,437.50.

b. CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t)

SynCardia Systems, Inc. submitted an application for approval of the CardioWest™ temporary Total Artificial Heart system (TAH-t) in FY 2009. The TAH-t is a technology that is used as a bridge to heart transplant device for heart transplant-eligible patients with end-stage biventricular failure. The TAH-t pumps up to 9.5 liters of blood per minute. This high level of perfusion helps improve hemodynamic function in patients, thus making them better heart transplant candidates.

The TAH-t was approved by the FDA on October 15, 2004, for use as a bridge to transplant device in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The TAH-t is intended to be used in hospital inpatients. One of the FDA's post-approval requirements is that the manufacturer agrees to provide a post-approval study demonstrating that success of the device at one center can be reproduced at other centers. The study was to include at least 50 patients who would be followed up to 1 year, including (but not limited to) the following endpoints: survival to transplant; adverse events; and device malfunction.

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

We indicated in the FY 2009 IPPS/RY 2009 LTCH PPS final rule (73 FR 48555) that, because Medicare's previous coverage policy with respect to this device had precluded payment from Medicare, we did not expect the costs associated with this technology to be

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

After evaluation of the newness, costs, and substantial clinical improvement criteria for new technology add-on payments for the TAH-t and consideration of the public comments we received in response to the FY 2009 IPPS/RY 2009 LTCH PPS proposed rule, we approved the TAH-t for new technology add-on payments for FY 2009 (73 FR 48557). We indicated that we believed the TAH-t offered a new treatment option that previously did not exist for patients with end-stage biventricular failure. However, we indicated that we recognized that Medicare coverage of the TAH-t is limited to approved clinical trial settings. The new technology add-on payment status does not negate the restrictions under the NCD nor does it obviate the need for continued monitoring of clinical evidence for the TAH-t. We remain interested in seeing whether the clinical evidence demonstrates that the TAH-t continues to be effective. If evidence is found that the TAH-t may no longer offer a substantial clinical improvement, we reserve the right to discontinue new technology add-on payments, even within the 2- to 3-year period that the device may still be considered to be new. We also continued to make new technology add-on payments for the TAH-t in FY 2010. We welcome public comment regarding whether there is new evidence that demonstrates that the TAH–t continues to be effective and whether it should still be considered to be a substantial clinical improvement for FY 2011.

The new technology add-on payment for the TAH-t for FY 2010 is triggered by the presence of ICD–9–CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). For FY 2010, we finalized a maximum add-on payment of $53,000 (that is, 50 percent of the estimated operating costs of the device of $106,000) for cases that involve this technology.

Our practice has been to begin and end new technology add-on payments on the basis of a fiscal year. In general, we extend add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year (70 FR 47362). The TAH-t is still eligible to be considered "new" for purposes of the new technology add-on payment because the 3-year anniversary date of the TAH-t entry on the market was in the second half of the fiscal year and the TAH-t met the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD, effective on May 1, 2008. Therefore, for FY 2011, we are proposing to continue new technology add-on payments for cases involving the TAH-t in FY 2011 with a maximum add-on payment of $53,000.

4. FY 2011 Applications for New Technology Add-On Payments

We received five applications to be considered for new technology add-on payment for FY 2011. However, two applicants withdrew their applications: Nycomed Austria GmbH, which submitted an application for new technology add-on payments for FY 2011 for TachoSil®; and Zimmer, which submitted an application for new technology add-on payments for FY 2011 for the Dynesys Dynamic Stabilization System. Nycomed Austria GmbH withdrew its application from further review in January 2010, and Zimmer withdrew its application in February 2010. Because both applications were withdrawn prior to the town hall meeting and publication of this proposed rule, we are not discussing these two applications in this proposed rule.

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

a. Auto Laser Interstitial Thermal Therapy (AutoLITT™) System

Monteris Medical submitted an application for new technology add-on payments for FY 2011 for the AutoLITT™. We note that the applicant submitted an application for new technology add-on payments for FY 2010 but withdrew its application prior to the FY 2010 IPPS/RY 2010 LTCH PPS final rule. AutoLITT™ is a minimally invasive, MRI-guided catheter tipped laser designed to destroy malignant brain tumors with interstitial thermal energy causing immediate coagulation and necrosis of diseased tissue. The applicant asserts that the AutoLITT™ delivers laser energy to the lesion with a proprietary 3mm diameter probe that directs the energy radially (that is, at right angle to the axis of the probe, or side-firing) toward the targeted tumor tissue in a narrow beam profile and at the same time, a proprietary probe cooling system removes heat from tissue not directly in the path of the laser beam, ostensibly protecting it from thermal damage and enabling the physician to selectively ablate only targeted tissue. The AutoLITT™ received a 510K FDA clearance in May 2009. The AutoLITT™ is indicated for use to necrotize or coagulate soft tissue through interstitial irradiation or thermal therapy in medicine and surgery in the discipline of neurosurgery with 1064 nm lasers. The AutoLITT™ may be used in patients with glioblastoma multiforme brain tumors. The applicant stated in its application and through supplemental information that, due to required

updates, the technology was actually introduced to the market in December 2009. The applicant explained that it was necessary to reduce the thermal damage lines from three to one and complete International Electrotechnical Commission/Underwriter Laboratory testing, which led to the introduction of the technology to the market in December 2009, although the technology was approved by FDA in May 2009. The applicant also stated through supplementary information to its application that the first sale of the product took place on March 19, 2010. However, because the product was already available for use in December 2009, it appears that the newness date would begin in December 2009. We welcome public comments on this issue.

With regard to the newness criterion, we are concerned that the AutoLITT™ may be substantially similar to the device that it listed as its predicate device in its application to the FDA for approval. Specifically, in making a determination of substantial similarity, we consider the following: (1) Whether a product uses the same or similar mechanism of action to achieve a therapeutic action; and (2) whether a product is assigned to the same of different MS–DRG; and (3) whether the new use of a technology involves the treatment of the same or similar type of disease and the same or similar patient population. The applicant identified Visual-ase as its predicate device (which was approved by the FDA in 2006), which is also used to treat tumors of the brain. The applicant maintains that AutoLITT™; can be distinguished from the Visual-ase by its mechanism of action (that is, side-firing laser versus elliptical firing). Additionally, as mentioned above, the technology contains a proprietary probe cooling system that removes heat from tissue not directly in the path of the laser beam. We welcome comments from the public regarding whether or not the AutoLITT™ is substantially similar to the Visual-ase and if it meets the newness criteria.

The technology can be identified by ICD–9–CM procedure codes 17.61 (Laser interstitial thermal therapy [LITT] of lesion or tissue of brain under guidance), and 17.62 (Laser interstitial thermal therapy [LITT] of lesion or tissue of head and neck under guidance), which were effective on October 1, 2009.

In an effort to demonstrate that AutoLITT™ meets the cost criterion, the applicant used 2007 Medicare data from the Healthcare Cost and Utilization Project (HCUP). We first note that the applicant believes that cases eligible for the AutoLITT™ will map to MS–DRG 25 (Craniotomy and Endovascular Intracranial Procedures with MCC), MS–DRG 26 (Craniotomy and Endovascular Intracranial Procedures with CC), and MS–DRG 27 (Craniotomy and Endovascular Intracranial Procedures without CC or MCC). The applicant explained through supplemental information to its application that most cases of the AutoLITT™ would map to MS–DRG 25 in the near-term. As the technology becomes more widely available, clinicians will use the technology instead of performing a craniotomy for brain cancer and on other different types of brain cancers including metastases, which would map to other MS–DRGs aside from MS–DRG 25. The applicant further stated that life expectancy with brain cancer is predicated on the removal of as much of the cancer as possible and asserted that over time the AutoLITT™ will do a better job of removing the majority of the cancer that is present within the brain tissue compared to other procedures. The applicant believes that physicians with the AutoLITT™ have a better tool at removing more cancer and killing it more precisely and accessing parts of the brain that surgical resection cannot access. Lastly, the applicant believes that the minimally invasive nature of the procedure will also result in broader usage to other less complicated procedures (as clinical and patient awareness expands).

The applicant searched HCUP hospital data for cases potentially eligible for the AutoLITT™ that was assigned one of the following ICD–9–CM diagnosis codes: a diagnosis code that begins with a prefix of 191 (Malignant neoplasm of brain); diagnosis code 225.0 (Benign neoplasm of brain and other parts of nervous system); or diagnosis code 239.6 (Neoplasm of the brain of unspecified nature). The applicant found 41,021 cases and weighted the standardized charge per case based on the number of cases found within each of the diagnosis codes listed above rather than the percentage of cases that would group to different MS–DRGs. Based on this analysis, the applicant calculated an average standardized charge per case was $57,511. While the applicant's analysis established a case-weighted average charge per case in the aggregate, it did not provide a case-weighted average standardized charge per case by MS–DRG (as required by the application).

The applicant also noted that their estimate of the case-weighted average standardized charge per case of $57,511 did not include charges related to the AutoLITT™. Therefore, it is necessary to add the charges related to the device to the case-weighted average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of the AutoLITT™ per case, the applicant stated that the cost of the device was proprietary information. Based on a study of charge compression data by RTI [4] and charge master data from Stanford University and University of California, San Francisco, the applicant estimates $38,886 in charges related to the AutoLITT™ (we note that some of the data used a markup of 294 percent of the costs). Adding the estimated charges related to the device to the average standardized charge per case resulted in a total average standardized charge per case of $96,397 ($57,511 plus $38,886). We note, in the applicant's discussion of substantial clinical improvement below, the applicant maintains that improved clinical outcomes using nonfocused LITT included reduced recovery time and a reduced rate of complications. Therefore, we are seeking comment on how reduced recovery time and a reduced rate of complications would affect the total case-weighted average standardized charge per case and the average length of stay (for cases eligible for the AutoLITT™).

As noted above, the applicant's analysis established a case-weighted average charge per case in the aggregate, but it did not provide a case-weighted average standardized charge per case by MS–DRG. However, the applicant explained through supplemental information to its application that the total average standardized charge per case significantly exceeds the cost threshold established by CMS for FY 2011 in Table 10 (74 FR 44173) of $84,185 for MS–DRG 25. Additionally, the applicant further explained that the total average standardized charge per case would also exceed the cost thresholds established by CMS of $58,612 for MS–DRGs 26 and $47,053 for MS–DRG 27. Because the total average standardized charge per case exceeds the threshold amount for each individual MS–DRG to which the technology would map (MS–DRGs 25, 26, and 27), the applicant maintains that the AutoLITT™ would meet the cost criterion. We invite public comment on whether or not the AutoLITT™ meets the cost criterion for a new technology add-on payment for FY 2011.

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

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

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

We appreciate the applicant's summary of why this technology represents a substantial clinical improvement. While we recognize the future potential of this interesting therapy, we have concerns that to date the AutoLITT™ has been used for the treatment of only a few patients as part of a safety evaluation with no comparative efficacy data and, therefore, there may not be sufficient objective clinical evidence to determine if the AutoLITT™ meets the substantial clinical improvement criteria. The applicant did note in its presentation at the new technology town hall meeting that it is currently conducting a clinical trial with a summary report expected in the near future. We welcome additional clinical data to demonstrate whether the AutoLITT™ meets the substantial clinical improvement criterion and invite public comment on whether or not the AutoLITT™ meets the substantial clinical improvement criterion.

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

b. LipiScan™ Coronary Imaging System

InfraReDx, Inc. submitted an application for new technology add-on payments for FY 2011 for the LipiScan™ Coronary Imaging System (LipiScan™). We note that an application was also submitted for FY 2010, but the application was denied on the grounds that it did not meet the substantial clinical improvement criterion at that time. The application for FY 2011 contains some additional clinical and charge data that were not available at the time that the FY 2010 new technology add-on payment decisions were made.

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

With regard to the newness criterion, the LipiScan™ received a 510K FDA clearance for a new indication on April 25, 2008, and was available on the market immediately thereafter. On June 23, 2006, InfraReDx, Inc. was granted a 510K FDA clearance for the "InfraReDx Near Infrared (NIR) Imaging System." Both devices are under the common name of "Near Infrared Imaging System" according to the 510K summary document from the FDA. However, the InfraReDx NIR Imaging System device that was approved by the FDA in 2006 was approved "for the near infrared imaging of the coronary arteries," whereas the Lipiscan™ device cleared by the FDA in 2008 is for a modified indication. The modified indication specified that Lipiscan™ is "intended for the near-infrared examination of coronary arteries* * *, the detection of lipid-core-containing plaques of interest* * *[and] for the assessment of coronary artery lipid core burden." In the FY 2010 IPPS/RY 201 LTCH PPS proposed rule (74 FR 24132 through 24134), we noted that we had concerns with whether Lipiscan™ was substantially similar to its predicate device that was approved by the FDA in 2006. However, those concerns were addressed by the manufacturer during the comment period. Specifically, the manufacturer stated that there were technical problems with the original device and that LipiScan™ had to be modified in the following ways:

	2006 NIRS device	Marketed 2008 lipiScan
Console	No display of results of scan	Results displayed immediately.
Catheter	Saline-filled with microbubble problem obscuring many scans.	Air-filled with no microbubble problem.

	2006 NIRS device	Marketed 2008 lipiScan
Algorithm	No algorithmic processing of NIR signals—no means of certifying that lipid core plaque is present.	Algorithm validated in over 1,000 autopsy measurements proving that NIRS can detect lipid core plaque, and providing diagnosis of lipid core plaque to the MD during the case.

The problems with the LipiScan™ device that was approved in 2006 were addressed in the second device that was granted FDA approval in April 2008. The LipiScan™ device was not marketed until after its second FDA clearance. Therefore, we no longer needed to make a determination as to whether the newer device was substantially similar to the predicate device and we determined in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43815) that Lipiscan™ would be considered to be "new" to the market as of the date of its FDA approval in April 2008. Because a technology may be considered new for a period of up to 3 years if, during the third year, the technology is new for more than 6 months of the fiscal year, it appears that the technology would still be in the newness period for FY 2011. We welcome public comment on whether Lipiscan™ meets the newness criterion.

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

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2010 final rule After Outliers Removed (AOR) file (posted on the CMS Web site) to identify cases potentially eligible for Lipiscan™. The applicant believes that every case within MS–DRGs 246, 247, 248, 249, 250, and 251 is eligible for Lipiscan™. In addition, the applicant believes that Lipiscan™ will be evenly distributed across patients in each of those six MS–DRGs (16.7 percent within each MS–DRG). Using data from the AOR file, the applicant found the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 was $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, equating to a case-weighted average standardized charge per case of $52,230 (calculation performed using unrounded numbers). The applicant indicated that the case-weighted average standardized charge per case does not include charges related to Lipiscan™; therefore, it is necessary to add the charges related to the device to the average case-weighted standardized charge per case to evaluate the cost threshold criterion. Although the applicant submitted data related to the estimated cost per case of Lipiscan™, the applicant stated that the cost of the device is proprietary information. Based on a sampling of all 10 non-VA hospitals that are actively using the device, the applicant determined that the average charge for the device was $7,497. Adding the estimated average charge related for the device to the case-weighted standardized charge per case (based on the case distribution from the applicant's FY 2010 AOR analysis) results in a total case-weighted average standardized charge per case of $59,727 ($52,230 plus $7,497). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,487 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ meets the cost criterion.

We note that in the applicant's analysis of the cost criterion, instead of determining the case-weighted average standardized charge per case and the case-weighted threshold amount based on the actual number of cases from the FY 2010 AOR file in the applicable MS–DRGs that are eligible for the Lipiscan™, the applicant's analysis assumed an even distribution of patients in the applicable MS–DRGs. However, the data from the FY 2010 AOR file shows a varied distribution of cases in each of the applicable MS–DRGs. We believe the more appropriate way to determine the case-weighted average standardized charge per case and the case-weighted threshold amount for evaluating the cost criterion is to use the actual distribution of cases in the applicable MS–DRGs based on the number of cases from the AOR file because this would more accurately reflect the number and type of Medicare cases typically treated in the applicable MS–DRGs. Moreover, this would better conform with the applicant's assertion that the probability of use of Lipiscan™ is the same in each of those six MS–DRGs. Using data from the FY 2010 AOR file, for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,411, 147,952, 19,736, 67,964, 8,184, and 38,091 cases, respectively. Using this case distribution and the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 from the application (that is, $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, as stated above), the case-weighted average standardized charge per case is $46,657. As the applicant indicated above, the case-weighted average standardized charge per case does not include charges related to Lipiscan™. Therefore, it is necessary to add the average charge of $7,497 related to the device to the case-weighted standardized charge per case to evaluate the cost threshold criterion. Adding the estimated charges related to the device to the case-weighted average standardized charge per case (based on the case distribution from the FY 2010 AOR final rule file) results in a total case-weighted average standardized charge per case of $54,154 ($46,657 plus $7,497). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) and the actual case distribution from the AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,700 (all calculations above were performed using unrounded numbers). Because this alternative calculation of total case-weighted average standardized charge per case for the applicable MS–DRGs also exceeds the case-weighted threshold amount, it appears that Lipiscan™ would meet the cost criterion. We invite public comment on

whether or not Lipiscan™ meets the cost criterion.

With regard to substantial clinical improvement, CMS determined that the FY 2010 new technology add-on payment application for Lipiscan™ did not meet the substantial clinical improvement criterion because the evidence and information available at the time the new technology decisions were made did not allow CMS to determine that the application represented a substantial clinical improvement over existing technologies. Specifically, CMS found that there was a lack of evidence that demonstrated that Lipiscan™ affected the medical management of patients in which the device was used.

The applicant maintains that the device meets this criterion for the following reasons. The applicant noted that from November 2008 to 2009, the number of patients in whom Lipiscan™ has been used for clinical purposes has increased from 100 to 500 and during the same period, the number of hospitals using the product has increased from 6 to 16. In addition, the applicant asserts that "during the past year, two Lipiscan™ publications demonstrate that dilation of a lipid core plaque is responsible for slow or no reflow and myocardial infarction during the procedure." The applicant noted that this is important because "several treatments are available that could prevent this stenting complication." The applicant referenced the "700 patient PROSPECT Study" which was presented at Transcatheter Cardiovascular Therapeutics Conference in September 2009 and found that 20.4 percent of patients experience a new event in the 3.4 years following stenting. The applicant pointed to that finding as evidence that there is a need for improved safety and efficacy of stenting and maintained that Lipiscan™ offers clinicians the ability to make decisions that result in such improvements.

The PROSPECT (Providing Regional Observations to Study Predictors of Events in the Coronary Tree) study is a cohort study of patients with acute coronary syndrome who underwent percutaneous coronary angioplasty and stenting (percutaneous coronary intervention). Following the procedure, angiography and intravascular ultrasound (IVUS) were performed. If a patient had a subsequent event, a new angiogram and IVUS image were obtained and compared to the original results. The investigators reported that "angiographically mild lesions with certain morphologic features on grayscale and IVUS present with a 3 year cardiac event rate of 17%, versus other morphologies (indistinguishable by conventional angiograms) with three year event risks of less than 1%." We are concerned that with this type of study design, it is not possible to determine whether the information for the IVUS image would have altered the angioplasty and stenting procedures since the images were collected after the procedure. The results are suggestive, but a prospective study is needed to determine the clinical utility of IVUS and whether use of IVUS leads to changes in clinical practice or improvements in health outcomes. The PROSPECT study generated a hypothesis that use of IVUS may help determine which plaques are vulnerable to future events but further clinical research is needed to confirm this hypothesis. We note that the PROSPECT study was presented at the Transcatheter Cardiovascular Therapeutics Conference in 2009, but that the study results have yet to be published in a peer-reviewed journal. We also note that methods and conclusions from a study may change from what was verbally presented during the peer review process that is required to publish the study results.

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

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

The applicant also noted that the device has the ability to make a diagnosis that better affects the management of the patient. Specifically, the applicant asserted that LipiScan™ "is currently used in the management of patients undergoing coronary stenting to improve the safety and efficacy of the procedure" and that while stenting has steadily improved, its results are not optimal in approximately 30 percent of cases due to 3 problems: (1) Peri-stenting MI due to embolization of lipid core contents and side branch occlusion; (2) major adverse coronary events (MACE) post stenting from difficulties at the stented site; and (3) MACE post stenting for non-stented vulnerable sites. We note that in order to demonstrate that the technology represents a substantial clinical improvement, there must be evidence that use of the device to make a diagnosis affects the medical management of the patient and leads to improved clinical outcomes.

The applicant described three case studies where each of the above problems was addressed by use of the LipiScan™. In addition, the applicant asserts that the chemogram results are available to the interventional cardiologist during the PCI procedure, and have been found to be useful in decision-making. According to the applicant, physicians have reported changes in therapy based on LipiScan™ findings in 20 to 50 percent of patients in which the device has been used. According to the applicant, the most common use of LipiScan™ results has been by physicians for selection of the length of artery to be stented. In some cases a longer stent has been used when there is a lipid-core-containing plaque adjacent to the area that is being stented because a flow-limiting stenosis is present. The applicant also noted that, in some cases, physicians have chosen to use down-stream protective devices during stenting procedures on the basis of information gathered by use of Lipiscan™ in several patients, and that this has directly impacted their outcome by capturing emboli and preventing further cardiac damage. Therefore, the applicant contends that the use of LipiScan™ by clinicians to select the length of artery to be stented and as an aid in selection of intensity of lipid-altering therapy, demonstrates that

LipiScan™ affects the management of patients.

While we recognize that the identification of lipid-rich plaques in the coronary vasculature holds promise in the management of coronary artery disease, we are concerned that statements in the FDA approval documents, as well as statements made by investigators in the literature, suggest that the clinical implications of identifying these lipid-rich plaques are not yet certain and that further studies need to be done to understand the clinical implications of obtaining this information.

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

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

We received approximately nine public comments during the town hall meeting public comment period on the LipiScan™ and LipiScan™ IVUS. The comments relating to LipiScan™ IVUS are summarized at the end of the LipiScan™ IVUS application.

Comment: Several commenters supported approving the LipiScan™ device for new technology add-on payments. They stated (using nearly identical language) that LipiScan™ provided accurate information about the presence of lipid core plaques that was previously unavailable. They also stated that the device "permits the detection of an earlier stage of coronary artery disease." The commenters also stated that, "over the past year evidence has been obtained documenting that the presence of a lipid-core plaque at a stenotic site (as detected by LipiScan™) is an excellent predictor or peri-stenting myocardial infarction due to distal embolization of the lipid core following balloon dilation. This valuable diagnostic information can be combined with well-established treatments (prophylactic administration of vasodilators and/or direct stenting) as a means to reduce the stenting complication of peri-stenting MI."

One commenter stated that "the knowledge that a patient possesses lipid laden atheroma will markedly alter medical therapy in order to prevent thrombotic events. These heretofore unrecognized (asymptomatic) patients identified to be at high risk by the Lipiscan chemogram will be treated with intensive antihyperlipdemic therapy and other medical strategies that otherwise would not have been implemented to modify risk." Some commenters indicated that other potential uses of LipiScan™ include "determination of the length of the artery to be stented and selection of the intensity of lipid-altering therapy."

Several commenters stated that the "lack of specific reimbursement" for the technology was an impediment to the use and development of it.

Response: We thank the commenters for their comments. We have considered the comments concerning the town hall meeting in this proposed rule. As stated above, we invite additional public comment on objective data regarding the assertions made by the commenters. Specifically, we welcome additional information (including specific case-descriptions) regarding how the use of the technology has affected the medical management of patients and how the changes in management have led to improved clinical outcomes for those patients (again, specific examples are welcomed).

In response to the comments concerning Medicare reimbursement for LipiScan™, we note that LipiScan™ is currently covered by Medicare and would thus be included in the MS–DRG payment made to the hospital. In general, the MS–DRG payment is considered to cover all costs associated with the case including those of new technologies. As noted above, typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the MS–DRG weights. In addition, Congress specified that a new medical service or technology may be considered for new technology add-on payment if, "based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate." While we agree with the commenter that at this time there is no specific reimbursement for Lipiscan™ within the MS–DRGs in the form of a new technology add-on payment, because Lipiscan™ has applied for new technology add-on payments, we will evaluate it to determine whether it meets the criteria to receive new technology add-on payments in FY 2011. If the technology does not meet the new technology add-on payment criteria, it will continue to be paid as part of the regular MS–DRG payment and once the lag of 2 to 3 years is over, the costs associated of Lipiscan™ will be fully reflected in the relative weights that are used to recalibrate the MS–DRGs.

c. LipiScan™ Coronary Imaging System With Intravascular Ultrasound (IVUS)

InfraReDx, Inc. submitted an application for new technology add-on payments for FY 2011 for the LipiScan™ Coronary Imaging System with Intravascular Ultrasound (LipiScan™ IVUS). The LipiScan™ IVUS device is a diagnostic device that uses Intravascular near infrared spectroscopy (INIRS) combined with intravascular ultrasound (IVUS) during an invasive coronary angiography to determine the chemical composition of coronary plaques, which is accomplished using near infrared spectroscopy (INIRS) and to visualize stents and the structural features of coronary lesions, which is accomplished using IVUS. This new technology combines both capabilities in a single catheter. The IVUS part of the device utilizes sound to interrogate the artery and, according to the applicant, provides an image of the size of the plaque, the degree of stenosis produced by the plaque, the size of the artery and the degree of expansion of the stent. The device consists of a single-use catheter, a console and a "single pullback with the artery." The

device is intended to be used in patients already undergoing coronary stenting.

With respect to the newness criterion, we note that this device is not currently approved by the FDA, but the manufacturer anticipates that FDA approval will be granted in the second quarter of 2010. We also note that IVUS has existed for over 20 years. Therefore, IVUS, on its own, would not meet the newness criterion. The applicant asserts that one difference from the Lipiscan™ product, for which it has also submitted an application for new technology add-on payments, is that the catheter for the combined product is filled with saline (which is required for transmission of sound). The manufacturer has also stated that the combined device only requires the use of one catheter, as opposed to two separate ones. The manufacturer asserts that the single-use catheter for the combined technologies is only supplied by InfraRedX (the manufacturer of LipiScan™). However, we note that a physician could use LipiScan™ and IVUS as two separate products in the same patient (through the use of two catheters) and still be able to obtain the INIRS image and the ultrasound that are achieved through the combined product albeit separately.

We welcome public comments regarding whether the combined LipiScan™ IVUS device should be considered to be "new" as of the date of the existing LipiScan™ device received FDA approval or whether it should be considered new from the FDA approval date for LipiScan™ IVUS (should such an approval be granted). We also welcome public comments regarding whether LipiScan™ IVUS, as a combined technology, should be considered to be substantially similar to each individual technology separately as of the date that each separate technology received FDA approval (or the date that each technology became available on the market, if either technology was not available on the market until a date after FDA approval).

As stated above, in making a determination of substantial similarity, we consider the following: (1) Whether a product uses the same or similar mechanism of action to achieve a therapeutic action; (2) whether a product is assigned to the same or a different DRG; and (3) whether new use of a technology involves treatment of the same or similar type of disease and the same or similar patient population. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that "due to the complexity of issues regarding the substantial similarity component of the newness criterion, it may be necessary to exercise flexibility when considering whether technologies are substantially similar to one another (74 FR 43813).

We note that the LipiScan™ IVUS device is identified by ICD–9–CM procedure codes 38.23 (Intravascular spectroscopy) and 00.24 (Intravascular imaging of coronary vessels). Cases involving the use of this device generally map to MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) without MCC); MS–DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) without MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent without MCC).

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2010 final rule After Outliers Removed (AOR) file (posted on the CMS Web site) to identify cases potentially eligible for Lipiscan™ IVUS. The applicant believes that every case within MS–DRGs 246, 247, 248, 249, 250, and 251 is eligible for Lipiscan™ IVUS. In addition, the applicant believes that Lipiscan™ IVUS will be evenly distributed across patients in each of those six MS–DRGs (16.7 percent within each MS–DRG). Using data from the AOR file, the applicant found the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 was $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864 respectively, equating to a case-weighted average standardized charge per case of $52,230 (calculation performed using unrounded numbers). The applicant indicated that the case-weighted average standardized charge per case does not include charges related to Lipiscan™ IVUS. Therefore, it is necessary to add the charges related to the device to the average case-weighted standardized charge per case to evaluate the cost threshold criterion. Although the applicant submitted data related to the estimated cost per case of Lipiscan™ IVUS, the applicant stated that the cost of the device is proprietary information. The applicant analyzed Hospital Cost Report Information System ("HCRIS") data from 2008 to determine the charges related to the device. Specifically, the applicant searched for the 100 cardiac catheterization labs that had the highest volume of cases in the United States. Based on the HCRIS data from these 100 labs, the applicant determined the mean cost-to-charge ratio was 0.188 with a mark-up of 532 percent yielding a charge of $15,957 for Lipiscan™ IVUS. (We note that this estimate of charges related to the Lipiscan™ IVUS is significantly higher than the estimate of charges related to the Lipiscan™ device.) Adding the estimated average charge related for the device to the case-weighted standardized charge per case (based on the case distribution from the applicant's FY 2010 AOR analysis) results in a total case-weighted average standardized charge per case of $68,190 ($52,230 plus $15,960). Using the FY 2011 thresholds published in Table 10 of the FY 2011 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,487 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ IVUS meets the cost criterion.

We note that in the applicant's analysis of the cost criterion, instead of determining the case-weighted average standardized charge per case and the case-weighted threshold amount based on the actual number of cases from the FY 2010 AOR file in the applicable MS–DRGs that are eligible for the Lipiscan™ IVUS, the applicant's analysis assumed an even distribution of patients in the applicable MS–DRGs. However, the data from the FY 2010 AOR file shows a varied distribution of cases in each of the applicable MS–DRGs. We believe the more appropriate way to determine the case-weighted average standardized charge per case and the case-weighted threshold amount for evaluating the cost criterion is to use the actual distribution of cases in the applicable MS–DRGs based on the number of cases from the AOR file because this would more accurately reflect the number and type of Medicare cases typically treated in the applicable MS–DRGs. Moreover, this would better conform with the applicant's assertion that that the probability of use of Lipiscan™ is the same in each of those six MS–DRGs. Using data from the FY 2010 AOR file, for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,411, 147,952, 19,736, 67,964, 8,184, and 38,091 cases, respectively. Using this case distribution and the average standardized charge per case for MS–

DRGs 246, 247, 248, 249, 250, and 251 from the application (that is, $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, as stated above), the case-weighted average standardized charge per case is $46,657. As the applicant indicated above, the case-weighted average standardized charge per case does not include charges related to Lipiscan™ IVUS. Therefore, it is necessary to add the average charge of $15,960 related to the device to the case-weighted standardized charge per case to evaluate the cost threshold criterion. Adding the estimated charges related to the device to the case-weighted average standardized charge per case (based on the case distribution from the FY 2010 AOR final rule file) results in a total case-weighted average standardized charge per case of $62,617 ($46,657 plus $15,960). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) and the actual case distribution from the AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,700 (all calculations above were performed using unrounded numbers). Because this alternative calculation of total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, it appears that Lipiscan™ IVUS would meet the cost criterion.

In addition to the analysis above, the applicant searched the FY 2008 MedPAR file for cases potentially eligible for use of the Lipiscan™ IVUS. Because the technology can potentially be used for all cases within MS–DRGs 246 through 251, the applicant searched the FY 2008 MedPAR file for all cases within these MS–DRGs. The applicant found 30,265 cases (or 9.7 percent of all cases) in MS–DRG 246; 147,695 cases (or 47.4 percent of all cases) in MS–DRG 247; 19,642 cases (or 6.3 percent of all cases) in MS–DRG 248; 67,840 cases (or 21.8 percent of all cases) in MS–DRG 249; 8,120 cases (or 2.6 percent of all cases) in MS–DRG 250; and 38,022 cases (or 12.2 percent of all cases) in MS–DRG 251. The average standardized charge per case was $66,958 for MS–DRG 246, $50,192 for MS–DRG 247, $72,099 for MS–DRG 248, $45,086 for MS–DRG 249, $71,355 for MS–DRG 250, and $46,141 for MS–DRG 251, equating to a case-weighted average standardized charge per case of $45,964.

Similar to above, the average standardized charge per case does not include charges related to the Lipiscan™ IVUS; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of Lipiscan™ IVUS per case, the applicant noted that the cost of the device was proprietary information. Based on 2008 HCRIS data from the cardiac catheterization laboratories for all IPPS hospitals, the applicant determined a mean cost-to-charge ratio of 0.246 with a markup of 351 percent, yielding a charge of $10,543 for Lipiscan™ IVUS. Assuming that the Lipiscan™ IVUS device was marked up 351 percent, the total case-weighted average standardized charge per case for cases involving the use of Lipiscan™ IVUS would be $56,507 ($45,964 plus $10,543) across MS–DRGs 246 through 251.

Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,692 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ IVUS meets the cost criterion. We invite public comment on whether or not Lipiscan™ IVUS meets the cost criterion.

With regard to substantial clinical improvement, the applicant asserts that LipiScan™ IVUS lends all the same benefits of LipiScan™ by itself (see discussion of LipiScan™ with respect to clinical improvement in the above application analysis) and also gives added benefits of IVUS. Specifically, the applicant maintains that LipiScan™ IVUS is superior to perfusion imaging and coronary angiography because those procedures only provide information about the lumen, but not the wall of the vessel. The applicant asserts that it is superior to IVUS (by itself) because IVUS alone cannot identify plaque composition. The applicant further maintains that LipiScan™ IVUS provides a substantial clinical benefit over Optical Coherence Tomography (OCT) because OCT cannot be used if blood is present in the field of view and identification of lipid by OCT is "time-consuming with a requirement for expert interpretation." In contrast, "the LipiScan™ signal is available immediately after the coronary pullback and does not require expert interpretation."

The applicant also states that LipiScan™ IVUS makes it possible to find the lipid core plaques that are strongly associated with peri-stenting MI and adverse events post MI that current methods of diagnosis fail to find.

Finally, the applicant asserts that LipiScan™ IVUS affects the management of the patient by improving the safety and efficacy of stenting. Further, the applicant states that while stenting has steadily improved, its results are not optimal in approximately 30% of cases due to 3 problems: (1) Peri-stenting MI due to embolization of lipid core contents and side branch occlusion; (2) major adverse coronary events (MACE) post stenting from difficulties at the stented site; and (3) MACE post stenting for non-stented vulnerable sites."

The applicant described three case studies where each of the above problems were addressed by use of the LipiScan™ IVUS. LipiScan™ IVUS achieves its utility to differentiate lipid core plaque from fibrotic plaque, a differentiation that cannot be made by angiography or grayscale IVUS.

The applicant referenced the "700 patient PROSPECT Study" which was presented at Transcatheter Cardiovascular Therapeutic Conference in September 2009 and found that 20.4 percent of patients experience a new event in the 3.4 years following stenting. The applicant pointed to that finding as evidence that there is a need for improved safety and efficacy of stenting and maintained that Lipiscan™ offers clinicians the ability to make decisions that result in such improvements.

The PROSPECT (Providing Regional Observations to Study Predictors of Events in the Coronary Tree) study is a cohort study of patients with acute coronary syndrome who underwent percutaneous coronary angioplasty and stenting (percutaneous coronary intervention). Following the procedure, angiography and IVUS were performed. If a patient had a subsequent event, a new angiogram and IVUS image were obtained and compared to the original results. The investigators reported that "angiographically mild lesions with certain morphologic features on grayscale and IVUS present with a 3 year cardiac event rate of 17%, versus other morphologies (indistinguishable by conventional angiograms) with three year event risks of less than 1%." We are concerned that with this type of study design, it is not possible to determine whether the information for the IVUS image would have altered the angioplasty and stenting procedures since the images were collected after the procedure. The results are suggestive, but a prospective study is needed to determine the clinical utility of IVUS

and whether use of IVUS leads to changes in clinical practice or improvements in health outcomes. The PROSPECT study generated a hypothesis that use of IVUS may help determine which plaques are vulnerable to future events but further clinical research is needed to confirm this hypothesis. We note that the PROSPECT study was presented at the Transcatheter Cardiovascular Therapeutics Conference in 2009, but that the study results have yet to be published in a peer reviewed journal. We also note that methods and conclusions from a study may change from what was verbally presented during the peer review process that is required to publish the study results.

We are concerned that, in the LipiScan™ IVUS application, the applicant has generally repeated the statements made regarding use of LipiScan™ alone and has not provided information that indicates that combined use of LipiScan™ plus IVUS offers additional clinical benefit. Indeed, we note that most of the studies that were presented in an effort to support that LipiScan™ by itself was a substantial clinical improvement, were also included to support the LipiScan™ IVUS application. The applicant did not present any published peer-reviewed journal articles that were specifically related to the clinical merits of the combined LipiScan™ IVUS device.

We welcome public comments on whether the LipiScan™ IVUS represents a substantial clinical improvement over existing technologies as well as public comments on what is the appropriate comparison for LipiScan™ IVUS.

As we noted at the end of the discussion of the LipiScan™ application, we received approximately nine public comments on both the LipiScan™ and the LipiScan™ IVUS applications.

Comment: Several commenters acknowledged that LipiScan™ IVUS is not yet approved by the FDA, but stated that they would support the LipiScan™ IVUS being approved for new technology add-on payments should FDA approval be granted. With regard to the clinical merits of LipiScan™ IVUS, the commenters stated that the LipiScan™ IVUS afforded all the same diagnostic abilities of the LipiScan™, but also provided the added benefit of IVUS, which has "been used in patients for over 20 years [and] is already supported by the [American College of Cardiologists and the American Hospital Association] for usage in stenting."

One commenter stated that once the LipiScan™ IVUS becomes approved by the FDA, he plans to use it in all of his patients who need IVUS imaging "because of the wealth of added information regarding the presence of lipid laden plaque, a harbinger of myocardial infarction and sudden death."

Response: We thank the commenters for their comments. However, we note that unless the technology is approved by the FDA by July 1, 2010, it cannot be approved for add-on payments in FY 2011 since it would not be considered "new." Should the technology receive FDA approval by July 1, 2010, we will take these comments into consideration in our review of the application for new technology add-on payments for FY 2011.

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

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2011 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.C. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section of the Act provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2011 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2011 is discussed in section II.A.4.b. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are proposing to apply beginning October 1, 2010 (the proposed FY 2011 wage index) appears under section III.D. of this preamble.

B. Wage Index Reform

1. Wage Index Study Required under the MIEA–TRHCA

a. Legislative Requirement

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

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

- Problems associated with the definition of labor markets for the wage index adjustment.
- The modification or elimination of geographic reclassifications and other adjustments.
- The use of Bureau of Labor of Statistics (BLS) data or other data or methodologies to calculate relative wages for each geographic area.

• Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.

• The feasibility of applying all components of CMS' proposal to other settings.

• Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.

• The effect that the implementation of the proposal would have on health care providers on each region of the country.

• Methods for implementing the proposal(s), including methods to phase in such implementations.

• Issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

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

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

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

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

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

Acumen's final report addressing the issues in section 106(b)(2) of the MIEA–TRHCA is divided into two parts. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43824), we provided a description of Acumen's analyses for both parts. The first part of Acumen's final report analyzed the strengths and weaknesses of the data sources used to construct the MedPAC and CMS indexes. The first part of the report was published on Acumen's Web site after the publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. In its conclusion, Acumen suggested that MedPAC's recommended methods for revising the wage index represented an improvement over the existing methods, and that the BLS data should be used so that the MedPAC approach can be implemented.

The second part of Acumen's final report focuses on the methodology of wage index construction and covers issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas, as well as reasons for differential impacts of shifting to a new index. Acumen published the second part of its final report in March 2010 on its Web site at: *http:/www./acumenllc.com/reports/cms.* In particular, the report analyzes MedPAC's recommended method of improving upon the definition of the wage areas used in the current wage index. MedPAC's method first blends MSA and county-level wages and then implements a "smoothing" step that limits differences in wage index values between adjacent counties to no more than 10 percent. Acumen found MedPAC's method to be an improvement over the current wage index construct. However, although MedPAC's method diminishes the size of differences between adjacent areas, Acumen suggested that MedPAC's method does not guarantee an accurate representation of a hospital labor market and would not necessarily eliminate or reduce hospitals' desire to reclassify for a higher wage index. Acumen recommended further exploration of labor market area definitions using a wage area framework based on hospital-specific characteristics, such as commuting times from hospitals to population centers, to construct a more accurate hospital wage index. Acumen suggested that such an approach offers the greatest potential for replacing or greatly reducing the need for hospital reclassifications and exceptions.

We indicated in the FY 2009 IPPS final rule (73 FR 48566) that, in developing any proposal(s) for additional wage index reform that may be included in the FY 2010 IPPS proposed rule, we would consider all of the public comments on the MedPAC recommendations that we had received in that proposed rulemaking cycle, along with the interim and final reports to be submitted to us by Acumen. As Acumen's study was not complete at the time of issuance of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we did not propose any additional changes to the hospital wage index for the FY 2010 IPPS. We also are not proposing any additional changes regarding reforming the wage index for the FY 2011 IPPS. We welcome comments regarding the second part of Acumen's final report.

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

To implement the requirements of section 106(b) of the MIEA–TRHCA and respond to MedPAC's recommendations in its June 2007 report to Congress, in the FY 2009 IPPS final rule (73 FR 48567 through 48574), we made the following policy changes relating to the hospital wage index. (We refer readers to the FY 2009 IPPS final rule for a full discussion of the basis for the proposals, the public comments received, and the FY 2009 final policy.) In the FY 2010 IPPS final rule (74 FR 43825), we reiterated these policy changes, especially as they related to the FY 2010 IPPS.

a. Reclassification Average Hourly Wage Comparison Criteria

In the FY 2009 IPPS final rule, we adopted the policy to adjust the reclassification average hourly wage standard, comparing a reclassifying hospital's (or county hospital group's) average hourly wage relative to the average hourly wage of the area to which it seeks reclassification. We provided for a phase-in of the adjustment over 2 years. For applications for reclassification for the first transitional year, FY 2010, the average hourly wage standards were set at 86 percent for urban hospitals and group reclassifications and 84 percent for rural hospitals. For applications for reclassification for FY 2011 (for which the application deadline was September 1, 2009) and for subsequent fiscal years, the average hourly wage standards are 88 percent for urban and group reclassifications and 86 percent for rural hospitals (§§ 412.230, 412.232, and 412.234 of the regulations). As stated above, these policies were adopted in the FY 2009 IPPS final rule and are reflected in the wage index in the Addendum to this proposed rule. We note that these criteria were recently changed by provisions of section 3137(c) of the PPACA (Pub. L. 111–148). We will address the changes made by Public Law 111–148 in a separate rulemaking document in the **Federal Register**.

b. Budget Neutrality Adjustment for the Rural and Imputed Floors

In the FY 2009 IPPS final rule (73 FR 48574 through 48575), we adopted State level budget neutrality (rather than the national budget neutrality adjustment) for the rural and imputed floors, effective beginning with the FY 2009

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

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

As stated above, these policies for the rural and imputed floors were adopted in the FY 2009 IPPS final rule and are reflected in the wage index in the Addendum to this proposed rule. However, these policies were recently changed by the provisions of section 3141 of the PPACA (Pub. L. 111–148). We will address the provisions of section 3141 of Public Law 111–148 in a separate rulemaking document in the **Federal Register**.

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

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

As with the FY 2010 final rule, in this FY 2011 proposed rule, we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we are proposing to determine a wage index for FY 2011 employing wage index data from hospital cost reports for cost reporting periods beginning during FY 2007 and using the CBSA labor market definitions. We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, it has been our longstanding policy that where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029) (regulations at § 412.64(b)(1)(ii)(A)).

On December 1, 2009, OMB announced changes to the principal cities and, if applicable, titles of a number of CBSAs and Metropolitan Divisions (OMB Bulletin No. 10–2). The changes to the principal cities and titles are as follows:

- San Marcos, TX qualifies as a new principal city of the Austin-Round Rock, TX CBSA. The new title is Austin-Round Rock-San Marcos, TX CBSA.
- Delano, CA qualifies as a new principal city of the Bakersfield, CA CBSA. The new title: Bakersfield-Delano, CA CBSA.
- Conroe, TX qualifies as a new principal city of the Houston-Sugar Land-Baytown, TX CBSA. The CBSA title is unchanged.
- North Port, FL qualifies as a new principal city of the Bradenton-Sarasota-Venice, FL CBSA. The new title is North Port-Bradenton-Sarasota, FL CBSA. The new code is CBSA 35840.
- Sanford, FL qualifies as a new principal city of the Orlando-Kissimmee, FL CBSA. The new title is Orlando-Kissimmee-Sanford, FL CBSA.
- Glendale, AZ qualifies as a new principal city of the Phoenix-Mesa-Scottsdale, AZ CBSA. The new title is Phoenix-Mesa-Glendale, AZ CBSA.
- Palm Desert, CA qualifies as a new principal city of the Riverside-San Bernardino-Ontario, CA CBSA. The CBSA title is unchanged.
- New Braunfels, TX qualifies as a new principal city of the San Antonio, TX CBSA. The new title is San Antonio-New Braunfels, TX CBSA.
- Auburn, WA qualifies as a new principal city of the Seattle-Tacoma-Bellevue, WA CBSA. The CBSA title is unchanged.

The changes to titles resulting from changes to the order of principal cities based on population are as follows:

- Rockville, MD replaces Frederick, MD as the second most populous principal city in the Bethesda-Frederick-Rockville, MD Metropolitan Division. The new title is Bethesda-Rockville-Frederick, MD Metropolitan Division.
- Rock Hill, SC replaces Concord, NC as the third most populous principal city in the Charlotte-Gastonia-Concord, NC–SC CBSA. The new title is Charlotte-Gastonia-Rock Hill, NC–SC CBSA.
- Joliet, IL replaces Naperville, IL as the second most populous principal city in the Chicago-Naperville-Joliet, IL Metropolitan Division. The new title is Chicago-Joliet-Naperville, IL Metropolitan Division.
- Crestview, FL replaces Fort Walton Beach, FL as the most populous principal city in the Fort Walton Beach-Crestview-Destin, FL CBSA. The new title is Crestview-Fort Walton Beach-Destin, FL CBSA. The new code is 18880.
- Hillsboro, OR replaces Beaverton, OR as the third most populous principal city in the Portland-Vancouver-Beaverton, OR–WA CBSA. The new title is Portland-Vancouver-Hillsboro, OR–WA CBSA.
- Steubenville, OH replaces Weirton, WV as the most populous principal city in the Weirton-Steubenville, WV–OH CBSA. The new title is Steubenville-Weirton, OH–WV CBSA. The new CBSA code is 44600.

The OMB bulletin is available on the OMB Web site at *http://www.whitehouse.gov/OMB—go* to "Agency Information" and click on "Bulletins". CMS will apply these changes to the IPPS beginning October 1, 2010.

D. Proposed Occupational Mix Adjustment to the Proposed FY 2011 Wage Index

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

than geographic differences in the costs of labor.

1. Development of Data for the Proposed FY 2011 Occupational Mix Adjustment Based on the 2007–2008 Occupational Mix Survey

As provided for under section 1886(d)(3)(E) of the Act, we collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program.

For the FY 2010 hospital wage index, we used occupational mix data collected on a revised 2007–2008 Medicare Wage Index Occupational Mix Survey (the 2007–2008 survey) to compute the occupational mix adjustment for FY 2010. (We refer readers to the FY 2010 IPPS final rule (74 FR 43827) for a detailed discussion of the 2007–2008 survey.) Again, for the proposed FY 2011 hospital wage index, we used data from the 2007–2008 survey (including revised data for 45 hospitals) to compute the proposed FY 2011 adjustment.

2. New 2010 Occupational Mix Survey for the FY 2013 Wage Index

As stated earlier, section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. We used occupational mix data collected on the 2007–2008 survey to compute the occupational mix adjustment for FY 2010 and the proposed FY 2011 wage index in this proposed rule. We also plan to use the 2007–2008 survey data for the FY 2012 wage index. Therefore, a new measurement of occupational mix will be required for FY 2013.

Since we implemented the 2007–2008 survey, we received several public comments suggesting further improvements to the occupational mix survey. Specifically, commenters recommended that CMS use the calendar year (that is, January 1 through December 31) as the 1-year reporting period instead of July 1 through June 30. Commenters also requested that CMS allow for a 6-month period after the end of the survey reporting period for hospitals to complete and submit their data to their Medicare fiscal intermediaries and MACs. The commenters suggested that these changes will allow hospitals more time to develop their occupational mix data before submitting the data to the Medicare contractors and CMS for use in development of the wage index. Based on these comments, we revised the occupational mix survey. The new 2010 survey (Form CMS–10079 (2010)) will provide for the collection of hospital-specific wages and hours data for calendar year 2010 (that is, payroll periods ending between January 1, 2010 and December 31, 2010) and will be applied beginning with the FY 2013 wage index.

On September 4, 2009, we published in the **Federal Register** a notice soliciting comments on the proposed 2010 survey (74 FR 45860). The comment period for the notice ended on November 3, 2009. After considering the comments we received, we made a few minor editorial changes and published the final 2010 survey in the **Federal Register** on January 15, 2010 (75 FR 2548). The survey was approved by OMB on February 26, 2010 (OMB control number 0938–0907) and is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage,* and through the fiscal intermediaries/MACs. Hospitals are required to submit their completed 2010 surveys to their fiscal intermediaries/MACs by July 1, 2011. The preliminary, unaudited 2010 survey data will be released in early October 2011, along with the FY 2009 Worksheet S–3 wage data, for the FY 2013 wage index review and correction process.

3. Calculation of the Proposed Occupational Mix Adjustment for FY 2011

For FY 2011 (as we did for FY 2010), we are proposing to calculate the occupational mix adjustment factor using the following steps:

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

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

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

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

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

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

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

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

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

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

salaries and wage-related costs for all other employees (from Step 7).

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

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

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed FY 2011 occupational mix adjusted national average hourly wage is $34.9124.

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

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above. The proposed FY 2011 occupational mix adjusted Puerto Rico-specific average hourly wage is $14.7567.

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

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Example of Occupational Mix Adjustment

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

Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupational Mix Adjustment Factor**	**Provider % by Total**
Registered Nurses	1,142,129	18,125,763	**72.43%**	$30.00	**$21.73**			
Licensed Practical Nurses and Surgical Technologists	67,860	404,822	**4.30%**	$20.00	**$0.86**			
Nursing Aides, Orderlies, & Attendants	279,177	1,762,579	**17.71%**	$13.00	**$2.30**			
Medical Assistants	87,622	577,045	**5.56%**	$12.00	**$0.67**			
Total Nurse Hours and Salaries	**1,576,788**	**20,870,209**			**$25.56**	**$27.00**	**1.0564**	**52.40%**
ALL OTHER	5,000,000	18,957,010			Step 4			**47.60%**
TOTAL	**6,576,788**	**$39,827,219**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$14,381,144**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$12,365,857**	Step 7						
Total Occupational Mix Wages	**$26,747,001**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.37**	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

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Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2011 wage index. For the FY 2007–2008 survey, the response rate was 90.4 percent.

In computing the proposed FY 2011 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area. We believe this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the proposed occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's proposed FY 2011 occupational mix adjusted wage index. In addition, if a hospital submitted a survey, but that survey data could not be used because we determine it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages were out of range (that is, unusually high or low), and the hospital did not provide sufficient documentation to explain the aberrancy, or the hospital did not submit any registered nurse salaries or hours data, we assigned the hospital the average occupational mix adjustment for the labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market area, we replicated Steps 1 through 6 of the calculation for the occupational mix adjustment. However, instead of performing these steps at the hospital level, we aggregated the data at the labor market area level. In following these steps, for example, for CBSAs that contain providers that did not submit occupational mix survey data, the occupational mix adjustment factor ranged from a low of 0.9252 (CBSA 17780, College Station-Bryan, TX), to a high of 1.1199 (CBSA 40980, Saginaw-Saginaw Township North, MI). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the area's total workers attributable to the area's total nursing category. For FY 2011, there are 5 CBSAs (that include 5 hospitals) for which we did not have occupational mix data for any of its hospitals. The CBSAs are:

- CBSA 21940 Fajardo, PR (one hospital)
- CBSA 22140 (Farmington, NM (one hospital)
- CBSA 36140 Ocean City, NJ (one hospital)
- CBSA 41900 San German-Cabo Rojo, PR (two hospitals)
- CBSA 49500 Yauco, PR (one hospital)

Since the FY 2007 IPPS final rule, we have periodically discussed applying a hospital-specific penalty to hospitals that fail to submit occupational mix survey data. (71 FR 48013 through 48014; 72 FR 47314 through 47315; 73 FR 48580; and 74 FR 43832). During the FY 2008 rulemaking cycle, some commenters suggested a penalty equal to a 1- to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. During the FY 2009 and FY 2010 rulemaking cycles, several commenters reiterated their view that full participation in the occupational mix survey is critical, and that CMS should develop a methodology that encourages hospitals to report occupational mix survey data but does not unfairly penalize neighboring hospitals. We indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that, while we were not proposing a penalty at that time, we would consider the public comments we previously received, as well as any public comments on the proposed rule, as we develop the proposed FY 2011 wage index.

To gain a better understanding of why some hospitals are not submitting the occupational mix data, beginning with the new 2010 occupational mix survey (discussed in section III.D.2. of this preamble), we will require hospitals that do not submit occupational mix data to provide an explanation for not complying with the submission requirements. We will instruct fiscal intermediaries/MACs to gather this information as part of the FY 2013 wage index desk review process. We note that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals.

E. Worksheet S–3 Wage Data for the Proposed FY 2011 Wage Index

The proposed FY 2011 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2007 (the FY 2010 wage index was based on data from cost reporting periods beginning during FY 2006).

1. Included Categories of Costs

The proposed FY 2011 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty)
- Home office costs and hours
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315))
- Wage-related costs, including pensions and other deferred compensation costs. We note that, for developing pension and deferred compensation costs for purposes of the wage index, CMS requires hospitals to comply with the requirements in 42 CFR 413.100, the Provider Reimbursement Manual (PRM), Part I, Sections 2140, 2141, and 2142, and related Medicare program instructions, as discussed in the cost reporting instructions for Worksheet S–3, Part II, Lines 13 through 20, and in the FY 2006 IPPS final rule (70 FR 47369). On March 28, 2008, CMS published Revision 436, a technical clarification to the PRM, Part I policies for pension and deferred compensation costs. In addition, in November 2009, CMS released, through a Joint Signature Memorandum, instructions and a spreadsheet to assist hospitals and Medicare contractors in determining the annual allowable defined benefit pension cost for the FY 2011 wage index (JSM/TDL–10061, 11–20–09, December 3, 2009). These instructions and spreadsheet crosswalk the current interest, liability, and normal cost terminology found in the Medicare reimbursement policies under Section 2142 of the PRM, Part I to the new terminology applicable under the Pension Protection Act of 2006. The spreadsheet and instructions can be downloaded from the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1231035&intNumPerPage=10.*

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2009, the wage index for FY 2010 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2011 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

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

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

F. Verification of Worksheet S–3 Wage Data

The wage data for the proposed FY 2011 wage index were obtained from Worksheet S–3, Parts II and III of the Medicare cost report for cost reporting periods beginning on or after October 1, 2006, and before October 1, 2007. For wage index purposes, we refer to cost reports during this period as the "FY 2007 cost report," the "FY 2007 wage data," or the "FY 2007 data." Instructions for completing Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual (PRM), Part II, sections 3605.2 and 3605.3. The data file used to construct the wage index includes FY 2007 data submitted to us as of March 3, 2010. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MACs to revise or verify data elements that resulted in specific edit failures. For the proposed FY 2011 wage index, we identified and excluded 14 providers with data that was too aberrant to include in the proposed wage index, although if data elements for some of these providers are corrected, we intend to include some of these providers in the FY 2011 final wage index. We instructed fiscal intermediaries/MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 14, 2010. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the FY 2011 IPPS final rule.

In constructing the proposed FY 2011 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2007, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397). For this proposed rule, we removed 8 hospitals that converted to CAH status between February 16, 2009, the cut-off date for CAH exclusion from the FY 2010 wage index, and February 15, 2010, the cut-off date for CAH exclusion from the FY 2011 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the proposed FY 2011 wage index is calculated based on 3,513 hospitals.

In the FY 2008 final rule with comment period (72 FR 47317) and the FY 2009 IPPS final rule (73 FR 48582), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2011 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. The proposed FY 2011 wage index in this proposed rule includes separate wage data for campuses of three multicampus hospitals.

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

G. Method for Computing the Proposed FY 2011 Unadjusted Wage Index

The method used to compute the proposed FY 2011 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the proposed FY 2011 wage index on wage data reported on the FY 2007 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2006, and before October 1, 2007. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2006 and reported a cost reporting period covering all of FY 2007. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2007 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2007 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2006, and before October 1, 2007), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and

the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. (We note that, beginning with FY 2008 (72 FR 47315), we include Lines 22.01, 26.01, and 27.01 of Worksheet S–3, Part II for overhead services in the wage index. However, we note that the wages and hours on these lines are not incorporated into Line 101, Column 1 of Worksheet A, which, through the electronic cost reporting software, flows directly to Line 1 of Worksheet S–3, Part II. Therefore, the first step in the wage index calculation for FY 2011 is to compute a "revised" Line 1, by adding to the Line 1 on Worksheet S–3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

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

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours because hospitals typically do not provide fringe benefits (wage-related costs) to contract personnel. Therefore, it is not necessary for the wage index calculation to exclude overhead wage-related costs for contract personnel. Further, if a hospital does contribute to wage-related costs for contracted personnel, the instructions for Lines 22.01, 26.01, and 27.01 require that associated wage-related costs be combined with wages on the respective contract labor lines.); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2003, through April 15, 2005, for private industry hospital workers from the BLS' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. We also note that, since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SICs), which no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and we are not proposing to make any changes to the usage for FY 2011. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment Factor
10/14/2006	11/15/2006	1.04377
11/14/2006	12/15/2006	1.04077
12/14/2006	01/15/2007	1.03786
01/14/2007	02/15/2007	1.03508
02/14/2007	03/15/2007	1.03243
03/14/2007	04/15/2007	1.02981
04/14/2007	05/15/2007	1.02709
05/14/2007	06/15/2007	1.02430
06/14/2007	07/15/2007	1.02153
07/14/2007	08/15/2007	1.01891
08/14/2007	09/15/2007	1.01643
09/14/2007	10/15/2007	1.01394
10/14/2007	11/15/2007	1.01127
11/14/2007	12/15/2007	1.00844
12/14/2007	01/15/2008	1.00556
01/14/2008	02/15/2008	1.00275
02/14/2008	03/15/2008	1.00000
03/14/2008	04/15/2008	0.99732

For example, the midpoint of a cost reporting period beginning January 1, 2007, and ending December 31, 2007, is June 30, 2007. An adjustment factor of 1.02153 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2007 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage (unadjusted for occupational mix) is $34.9330.

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

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage (unadjusted for occupational mix) of $14.7351 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. The areas affected by this provision are identified in Table 4D–2 of the Addendum to this proposed rule.

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

H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2011 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2011, we are proposing to apply the occupational mix adjustment to 100 percent of the proposed FY 2011 wage index. We calculated the proposed occupational mix adjustment using data from the 2007–2008 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY 2011 wage index results in a proposed national average hourly wage of $34.9124 and a proposed Puerto-Rico specific average hourly wage of $14.7567. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2007 Worksheet S–3 cost report data for use in calculating the proposed FY 2011 wage index, we calculated the proposed FY 2011 wage index using the occupational mix survey data from 3,178 hospitals. Using the Worksheet S–3 cost report data of 3,513 hospitals and occupational mix survey data from 3,178 hospitals represents a 90.4 percent survey response rate. The proposed FY 2011 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN	36.100857731
National LPN and Surgical Technician	20.877391755
National Nurse Aide, Orderly, and Attendant	14.632232352
National Medical Assistant	16.482939594
National Nurse Category	30.504184147

The proposed national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $30.504184147. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the 2007–2008 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the national percentage of hospital employees in the nurse category is 44.32 percent, and the national percentage of hospital employees in the all other occupations category is 55.68 percent. At the CBSA level, the percentage of hospital employees in the nurse category ranged from a low of 29.08 percent in one CBSA, to a high of 70.76 percent in another CBSA.

We compared the proposed FY 2011 occupational mix adjusted wage indices for each CBSA to the proposed unadjusted wage indices for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the proposed wage index values for 203(51.9 percent) urban areas and 32 (68.1 percent) rural areas would increase. One hundred five (26.9 percent) urban areas would increase by 1 percent or more, and 6 (1.5 percent) urban areas would increase by 5 percent or more. Eighteen (38.3 percent) rural areas would increase by 1 percent or more, and no rural areas would increase by 5 percent or more. However, the wage index values for 188 (48.1 percent) urban areas and 15 (31.9 percent) rural areas would decrease. Ninety (23.0 percent) urban areas would decrease by 1 percent or more, and no urban area would decrease by 5 percent or more. Seven (14.9 percent) rural areas would decrease by 1 percent or more, and no rural areas will decrease by 5 percent or more. The largest positive impacts are 7.83 percent for an urban area and 2.87 percent for a rural area. The largest negative impacts are 3.98 percent for an urban area and 2.41 percent for a rural area. No urban or rural areas are unaffected. These results indicate that a larger percentage of rural areas (68.1 percent) benefit from the occupational mix adjustment than do urban areas (51.9 percent). While these results are more positive overall for rural areas than under the previous occupational mix adjustment that used survey data from 2006, approximately one-third (31.9 percent) of rural CBSAs will still experience a decrease in their wage indices as a result of the occupational mix adjustment.

The proposed wage index values for FY 2011 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) included in Tables 4A, 4B, 4C, and 4F of the Addendum to this proposed rule include the proposed occupational mix adjustment.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation or reclassification of hospitals based on FYs 2009, 2010, and 2011 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 2005 and FY 2006 cost reporting periods, as well as the FY 2007 period used to calculate the proposed FY 2011 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period. The proposed average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the proposed occupational mix adjustment. The proposed wage index values in Tables 4A, 4B, 4C, and 4D–1 also include the proposed State-specific rural floor and imputed floor budget neutrality adjustments.

I. Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

1. General

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). Generally, hospitals must be proximate to the labor market area to which they

are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use average hourly wage data from the 3 most recently published hospital wage surveys in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at 42 CFR 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the labor market area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. In light of the CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. Eligible counties are discussed and identified under section III.I.5. of this preamble.

2. Effects of Reclassification/ Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals are applicable both to the hospitals deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS also has adopted the following policies:

- The wage data for a reclassified urban hospital is included in both the wage index calculation of the urban area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- In cases where hospitals have reclassified to rural areas, such as urban hospitals reclassifying to rural areas under 42 CFR 412.103, the hospital's wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located. The effect of this policy, in combination with the statutory requirement at section 1886(d)(8)(C)(ii) of the Act, is that rural areas may receive a wage index based upon the highest of: (1) Wage data from hospitals geographically located in the rural area; (2) wage data from hospitals geographically located in the rural area, but excluding all data associated with hospitals reclassifying out of the rural area under section 1886(d)(8)(B) or section 1886(d)(10) of the Act; or (3) wage data associated with hospitals geographically located in the area plus all hospitals reclassified into the rural area.

In addition, in accordance with the statutory language referring to "hospitals" in the plural under sections 1886(d)(8)(C)(i) and 1886(d)(8)(C)(ii) of the Act, our longstanding policy is to consider reclassified hospitals as a group when deciding whether to include or exclude them from both urban and rural wage index calculations.

3. FY 2011 MGCRB Reclassifications

a. FY 2011 Reclassifications Requirements and Approvals

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in 42 CFR 412.230 through 412.280.

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2011 reclassification requests. Based on such reviews, there were 311 hospitals approved for wage index reclassifications by the MGCRB for FY 2011. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2011, hospitals reclassified during FY 2009 or FY 2010 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 258 hospitals approved for wage index reclassifications in FY 2009 and 254 hospitals approved for wage index reclassifications in FY 2010. Of all of the hospitals approved for reclassification for FY 2009, FY 2010, and FY 2011, based upon the review at the time of this proposed rule, 832 hospitals are in a reclassification status for FY 2011.

Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the

publication of a proposed rule. Generally stated, the request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2011 has to be received by the MGCRB within 45 days of the publication of the proposed rule. Hospitals may also cancel prior reclassification withdrawals or terminations in certain circumstances. For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to 42 CFR 412.273, as well as the FY 2002 IPPS final rule (66 FR 39887) and the FY 2003 IPPS final rule (67 FR 50065). Additional discussion on withdrawals and terminations, and clarifications regarding reinstating reclassifications and "fallback" reclassifications, were included in the FY 2008 IPPS final rule (72 FR 47333).

Changes to the wage index that result from withdrawals of requests for reclassification, terminations, wage index corrections, appeals, and the Administrator's review process for FY 2011 will be incorporated into the wage index values published in the FY 2011 IPPS/LTCH PPS final rule. These changes affect not only the wage index value for specific geographic areas, but also the wage index value redesignated/reclassified hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated/reclassified hospitals. Further, the wage index value for the area from which the hospitals are redesignated/reclassified may be affected.

b. Applications for Reclassifications for FY 2012

Applications for FY 2012 reclassifications are due to the MGCRB by September 1, 2010. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2010, via the CMS Internet Web site at: *http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp,* or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

c. Appeals of MGCRB Denials of Withdrawals and Terminations

Section 412.278 of the regulations permits a hospital or a group of hospitals dissatisfied with the MGCRB's decision regarding its geographic designation to request the Administrator's review of the decision. Section 412.273(e) permits a hospital to file an appeal to the Administrator regarding the MGCRB's denial of the hospital's request for withdrawal of an application. However, currently, this section of the regulations does not address Administrator review of the MGCRB's denial of a hospital's request for termination; that is, "terminations" are not specified in the regulations at § 412.273(e).

We are proposing to revise the regulations to specify the availability of Administrator review of MGCRB decisions regarding withdrawals and terminations, as well as cancellations of withdrawals or terminations. Because reclassifications are considered budget neutral actions, we believe these proposed revisions would have no impact on total IPPS payments.

In addition, during our review of § 412.273, we determined that some of the existing language in the section could be clarified to make it more easily understood. For example, we believe it would be helpful to clarify the distinction between terminations and withdrawals by defining these terms in a new paragraph (a), which would also include the timing provisions now under existing paragraph (b)(1)(ii). To account for this new paragraph, we are proposing to redesignate the existing contents of paragraph (e) as paragraph (f) and also to revise the language to specify the ability of a hospital to appeal an MGCRB denial of a request for "termination" of an approved reclassification, as well as cancellation of a withdrawal or termination. We also believe it would be helpful (1) to establish the introductory language of existing paragraph (a) as a general rule under new paragraph (b); (2) to establish a new paragraph (c) that addresses the timing provisions currently in paragraphs (a)(1), (a)(2), and (b)(1)(i); (3) to clarify the existing language of paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iii), and (d) and incorporate it under new paragraph (d); and (4) to redesignate the existing contents of paragraph (c) as new paragraph (e).

4. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act

Section 1886(d)(8)(B) of the Act requires us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met. Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals qualify under section 1886(d)(8)(B) of the Act to receive the wage index of the urban area. Hospitals located in these counties have been known as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. We provide the FY 2011 chart below with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act. For discharges occurring on or after October 1, 2010, hospitals located in the rural county in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

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Rural Counties Containing Hospitals Redesignated as Urban under Section 1886(d)(8)(B) of the Act (Based on CBSAs and Census 2000 Data)

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

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

Rural County	CBSA
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA
Page, VA	Harrisonburg, VA
Shenandoah, VA	Winchester, VA-WV
Island, WA	Seattle-Bellevue-Everett, WA
Mason, WA	Olympia, WA
Wahkiakum, WA	Longview, WA
Jackson, WV	Charleston, WV
Roane, WV	Charleston, WV
Green, WI	Madison, WI
Green Lake, WI	Fond du Lac, WI
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI
Walworth, WI	Milwaukee-Waukesha-West Allis, WI

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As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals may compare the reclassified wage index for the labor market area in Table 4C in the Addendum to the proposed rule into which they would be reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MGCRB reclassification within 45 days of the publication of this proposed rule.

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

As discussed in the FY 2009 IPPS final rule (73 FR 48588), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MGCRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). In accordance with policy adopted in the FY 2009 IPPS final rule (73 FR 48568 and 48569), beginning with reclassifications for the FY 2010 wage index, a Lugar hospital must also demonstrate that its average hourly wage is equal to at least 84 percent (for FY 2010 reclassifications) and 86 percent (for reclassifications for FY 2011 and subsequent fiscal years) of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

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

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

Section 508 of Public Law 108–173 allowed certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive under the law. Although section 508 originally was scheduled to expire after a 3-year period, Congress extended the provision several times, as well as certain special exceptions that would have otherwise expired. For a discussion of the original section 508 provision and its various extensions, we refer readers to the FY 2009 IPPS final rule (73 FR 48588). The most recent extension of the provision was included in section 124 of Public Law 110–275 (MIPPA). Section 124 extended, through FY 2009, section 508 reclassifications as well as certain special exceptions. Because the section 124 extension of these provisions expired on September 30, 2009 (and, therefore, will not be applicable in FY 2011 unless there is intervening legislation to extend the provisions), we are not proposing to make any changes related to these provisions in this proposed rule for FY 2011.

We note that section 508 and special exceptions reclassifications were recently extended again, through September 30, 2010, under section 10317 of the PPACA (Pub. L. 111–148). We intend to imminently issue instructions regarding implementation of section 10317 of Public Law 111–148.

J. Proposed FY 2011 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the "out-migration" adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. Beginning with the FY 2008 wage index, we use post-reclassified wage indices when determining the out-migration adjustment (72 FR 47339).

For the proposed FY 2011 wage index, we are proposing to calculate the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

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

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

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

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

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 2010 will be eligible to retain the adjustment for FY 2011. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2010.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FYs 2005 through 2010 IPPS final rules, we are specifying that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification adjustment, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment unless they explicitly notify CMS within 45 days from the publication of this proposed rule that they elect to receive the out-migration adjustment instead. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Table 4J in the Addendum to this proposed rule lists the proposed out-migration wage index adjustments for FY 2011. Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act will automatically receive the listed adjustment. In accordance with the procedures discussed above, redesignated/reclassified hospitals will be deemed to have waived the out-migration adjustment unless CMS is otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification will automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule. The wage index is updated annually and, as such, hospitals wishing to waive their Lugar redesignation in order to receive their home area wage index plus the out-migration adjustment must request the waiver annually.

K. Process for Requests for Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data and occupational mix survey data files for the proposed FY 2011 wage index were made available on October 5, 2009, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we post an additional public use file on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this new file does not alter the current wage index process or schedule. We notified the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door forum. We encouraged hospitals to sign up for automatic notifications of information about hospital issues and the scheduling of the Hospital Open Door forums at: *http://www.cms.hhs.gov/OpenDoorForums/*.

In a memorandum dated October 21, 2009, we instructed all fiscal intermediaries/MACs to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries/MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 5, 2009 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary/MAC by December 7, 2009. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data files on the Internet, through the October 21, 2009 memorandum referenced above.

In the October 21, 2009 memorandum, we also specified that a hospital requesting revisions to its occupational mix survey data was to copy its record(s) from the CY 2007–2008 occupational mix preliminary files posted to our Web site in October, highlight the revised cells on its spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal intermediary/MAC no later than December 7, 2009.

The fiscal intermediaries/MACs notified the hospitals by mid-February 2010 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries/MACs also submitted the revised data to CMS by mid-February 2010. CMS published the proposed wage index public use files that included hospitals' revised wage index data on February 22, 2010. Hospitals had until March 8, 2010, to submit requests to the fiscal intermediaries/MACs for reconsideration of adjustments made by the fiscal intermediaries/MACs as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals also were required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/MACs are to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2010. The deadline for a hospital to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations is April 21, 2010.

Hospitals should examine Table 2 in the Addendum to this proposed rule. Table 2 in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2007 data used to construct the proposed FY 2011 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS in March 2010.

We will release the final wage index data public use files by May 7, 2010 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*. The May 2010 public use files are made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary/MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the fiscal intermediaries/MACs by April 14, 2010). If, after reviewing the May 2010 final files, a hospital believes that its wage or occupational mix data are incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital should send a letter to both its fiscal intermediary/MAC and CMS that outlines why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) must receive these requests no later than June 7, 2010.

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

At this point in the process, that is, after the release of the May 2010 wage index data files, changes to the wage and occupational mix data will only be made in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS will approve the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 21, 2010.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 22, 2010 wage index public use files.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MACs (that is, by June 7, 2010) will be incorporated into the final wage index in the FY 2011 IPPS/LTCH PPS final rule, which will be effective October 1, 2010.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2011 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's (or, if applicable, the MAC's) decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W. A. Foote Memorial Hospital v. Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003).) We refer readers also to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention. Moreover, because hospitals have access to the final wage index data by early May 2010, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2011 wage index by August 2010, and the implementation of the FY 2011 wage index on October 1, 2010. If hospitals availed themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that

errors are identified by hospitals and brought to our attention after June 7, 2010, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, "before the beginning of the fiscal year" means by the June 7 deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, because CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries or the MACs notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is, beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or, if applicable, the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 7, 2010 deadline for the FY 2011 wage index); and (3) CMS agreed that the fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June 7, 2010 deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS' or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; and it can only be used for the current Federal fiscal year. In other situations where our policies would allow midyear corrections, we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

L. Labor-Related Share for the Proposed FY 2011 Wage Index

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: "The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *" We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of Public Law 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this "would result in lower payments to a hospital than would otherwise be made." However, this provision of Public Law 108–173 did not change the legal requirement that the Secretary estimate "from time to time" the proportion of hospitals' costs that are "attributable to wages and wage-related costs." We believe that this reflected Congressional intent that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43850 through 43856), we rebased and revised the hospital market basket for operating costs. We established a FY 2006-based IPPS hospital market basket to replace the FY 2002-based IPPS hospital market basket, effective October 1, 2009. In that final rule, we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2010. We also recalculated a labor-related share of 68.8 percent, using the FY 2006-based IPPS market basket, for discharges occurring on or after October 1, 2009. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. In this proposed rule, we are not proposing to make any further changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, contract labor, the labor-related portion of professional fees, administrative and business support services, and all other labor-related services (previously referred to in the FY 2002-based IPPS market basket as labor-intensive). Therefore, we are proposing to continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2010. Tables 1A and 1B in the Addendum to this proposed rule reflects this proposed labor-related share. We note that section 403 of Public Law 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment "would result in lower payments to a hospital than would otherwise be made." Therefore, for all IPPS hospitals whose wage indices are less than 1.0000, we are applying the wage index to a labor-related share of 62

percent of the national standardized amount. For all IPPS hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 68.8 percent of the national standardized amount.

For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. We are proposing to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 62.1 percent for discharges occurring on or after October 1, 2010. This Puerto Rico labor-related share of 62.1 percent was also adopted in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43857) at the time the FY 2006-based hospital market basket was established, effective October 1, 2009. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, the labor-related portion of professional fees, administrative and business support services, and all other labor-related services (previously referred to in the FY 2002-based IPPS market basket as labor-intensive) to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. The labor-related share of a hospital's Puerto Rico-specific rate will be either the Puerto Rico-specific labor-related share of 62.1 percent or 62 perecent, depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62.1 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 62 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The proposed Puerto Rico labor-related share of 62.1 percent for FY 2011 is reflected in the Table 1C of the Addendum to this proposed rule.

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

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

1. Background

a. Overview

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

CMS has implemented quality measure reporting programs for multiple settings of care. To measure the quality of hospital inpatient services, CMS implemented the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. In addition, CMS has implemented quality reporting programs for hospital outpatient services, the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), and for physicians and other eligible professionals, the Physician Quality Reporting Initiative (PQRI). CMS has also implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

b. Hospital Quality Data Reporting Under Section 501(b) of Public Law 108–173

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added section 1886(b)(3)(B)(vii) to the Act. This section established the authority for the RHQDAPU program and revised the mechanism used to update the standardized payment amount for inpatient hospital operating costs. Specifically, section 1886(b)(3)(B)(vii)(I) of the Act, before it was amended by section 5001(a) of Public Law 109–171, provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for FY 2005 through FY 2007 for any subsection (d) hospital that did not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. It also provides that any reduction would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. The statute thereby established an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary, and also built upon the previously established Voluntary Hospital Quality Data Reporting Program that we described in the FY 2009 IPPS final rule (73 FR 48598).

We implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (69 FR 49078) and codified the applicable percentage change in § 412.64(d) of our regulations. We adopted additional requirements under the RHQDAPU program in the FY 2006 IPPS final rule (70 FR 47420).

c. Hospital Quality Data Reporting Under Section 5001(a) of Public Law 109–171

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, further amended section 1886(b)(3)(B) of the Act to revise the mechanism used to update the standardized payment amount for hospital inpatient operating costs, in particular, by adding new section 1886(b)(3)(B)(viii) to the Act. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit quality data in a form and manner, and at a time, specified by the Secretary. Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year. In the FY 2007 IPPS final rule (71 FR 48045), we amended our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for subsection (d) hospitals that do not comply with requirements for reporting quality data, as provided for under section 1886(b)(3)(B)(viii) of the Act.

(1) Quality Measures

Section 1886(b)(3)(B)(viii)(III) of the Act requires that the Secretary expand the "starter set" of 10 quality measures that was established by the Secretary as of November 1, 2003, as the Secretary

determines to be appropriate for the measurement of the quality of care furnished by a hospital in inpatient settings. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act requires that, effective for payments beginning with FY 2007, the Secretary begin to adopt the baseline set of performance measures as set forth in a report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173.[5]

Section 1886(b)(3)(B)(viii)(V) of the Act requires that, effective for payments beginning with FY 2008, the Secretary add other quality measures that reflect consensus among affected parties, and to the extent feasible and practicable, have been set forth by one or more national consensus building entities. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. The NQF was established to standardize health care quality measurement and reporting through its consensus development process. We have generally adopted NQF-endorsed measures. However, we believe that consensus among affected parties also can be reflected by other means, including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment.

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

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

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

In the FY 2008 IPPS final rule (72 FR 47348 through 47358) and the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875 through 66877), we added three additional process measures to the RHQDAPU program measure set. (These three measures are SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose, SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal, and Pneumonia 30-day mortality (Medicare patients).) The addition of these 3 measures brought the total number of RHQDAPU program measures to be used for the FY 2009 payment determination to 30 (72 FR 66876). The 30 measures used for the FY 2009 annual payment determination are listed in the FY 2009 IPPS final rule (73 FR 48600 through 48601).

For the FY 2010 payment determination, we added 15 new measures to the RHQDAPU program measure set and retired one measure from the program (PN–1: Oxygenation Assessment). Of the new measures, 13 were adopted in the FY 2009 IPPS final rule (73 FR 48602 through 48611) and two additional measures were finalized in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780 through 68781). This resulted in an expansion of the RHQDAPU program measures from 30 measures for the FY 2009 payment determination to 44 measures for the FY 2010 payment determination. The RHQDAPU program measures for the FY 2010 payment determination consist of: 26 chart-abstracted process measures, which measure quality of care provided for Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), and Surgical Care Improvement (SCIP); 6 claims-based measures, which evaluate 30-day mortality and 30-day readmission rates for AMI, HF, or PN; 9 claims-based AHRQ patient safety indicators and inpatient quality indicators; 1 claims-based nursing sensitive measure; 1 structural measure that assesses participation in a systematic database for cardiac surgery; and the HCAHPS patient experience of care survey. The measures are listed in the IPPS FY 2009 final rule at 73 FR 46809 and in the CY 2009 OPPS/ASC final rule with comment period at 73 FR 68781.

On December 31, 2008, CMS advised hospitals that they would no longer be required to submit data for the RHQDAPU program measure AMI–6–Beta blocker at arrival, beginning with discharges occurring on April 1, 2009. This change was based on the evolving evidence regarding AMI patient care, as well as changes in the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines for ST-segment elevation myocardial infarction and non-ST segment elevation myocardial infarction, upon which AMI-6 is based. CMS took action to remove the measure from reporting initiatives based on the lack of support by the measure developer and the clinical and scientific considerations described in the FY 2010 IPPS/RY 2010 LTCH PPS final rule at 74 FR 43863.

We had previously discussed considerations relating to retiring or replacing measures in the FY 2008 IPPS final rule with comment period and the FY 2009 IPPS final rule, including the "topping out" of hospitals' performance under a measure (72 FR 47358 through 47359 and 73 FR 48603 through 48604, respectively). However, in this instance, the measure no longer "represent[s] the best clinical practice," an additional basis under section 1886(b)(3)(B)(viii)(VI) of the Act for retiring a measure. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we formally retired the AMI–6 measure from the RHQDAPU program for the FY 2011 payment determination and subsequent payment determinations.

For the FY 2011 payment determination, we retained 41 of the FY 2010 quality measures; harmonized two FY 2010 RHQDAPU program quality measures (combining PSI 04—Death among surgical patients with treatable serious complications; and Nursing Sensitive-Failure to rescue into a single measure (Death among surgical inpatients with serious, treatable complications); added two chart-abstracted measures (SCIP-Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 and SCIP-Infection-10: Perioperative Temperature Management); and added two structural measures (1) Participation in a Systematic Clinical Database Registry for Stroke Care; and (2) Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care) (74 FR 43868 through 43873). The 46 measures

[5] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at: *http://www.iom.edu/CMS/3809/19805/31310.aspx*. IOM set forth these baseline measures in a November 2005 report. However, the IOM report was not released until December 1, 2005 on the IOM Web site.

we adopted for the FY 2011 payment determination are:

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Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination as Finalized in FY 2010 IPPS/RY 2010 LTCH PPS Final Rule
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination as Finalized in FY 2010 IPPS/RY 2010 LTCH PPS Final Rule
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2*
	• SCIP-Infection-10: Perioperative Temperature Management*
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Mortality for selected surgical procedures (composite)
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care**	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care*
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care*

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(2) Maintenance of Technical Specifications for Quality Measures

The technical specifications for the RHQDAPU program measures, or links to Web sites hosting technical specifications, are contained in the CMS/The Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual). This Specifications Manual is posted on the CMS QualityNet Web site at *https://www.QualityNet.org/.* We maintain the technical specifications by updating this Specifications Manual semiannually, or more frequently in unusual cases, and include detailed instructions and calculation algorithms for hospitals to use when collecting and submitting data on required measures. These semiannual updates are accompanied by notifications to users, providing sufficient time between the change and the effective date in order to allow users to incorporate changes and updates to the specifications into data collection systems.

(3) Public Display of Quality Measures

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review its data before they are made public. To meet this requirement, data from the RHQDAPU program are typically displayed on CMS Web sites such as the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov* after a 30-day preview period. An interactive Web tool, this Web site assists beneficiaries by providing information on hospital quality of care to those who need to select a hospital. It further serves to encourage beneficiaries to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish. The RHQDAPU program currently includes process of care measures, risk adjusted outcome measures, the HCAHPS patient experience of care survey, and structural measures, all of which are featured on the *Hospital Compare* Web site. However, information that may not be salient to or understood by beneficiaries and information for which there are unresolved display issues or design considerations for inclusion on *Hospital Compare* may be made available on other CMS Web sites that are not intended to be used as an interactive Web tool, such as *http://www.cms.hhs.gov/HospitalQualityInits/.* Publicly reporting the information in this manner, though not on the *Hospital Compare* Web site, allows CMS to meet the requirement under section 1886(b)(3)(B)(viii)(VII) of the Act for establishing procedures to make quality data used for RHQDAPU payment determinations available to the public following a preview period. In such circumstances, affected parties are notified via CMS listservs, CMS e-mail blasts, national provider calls, and QualityNet announcements regarding the release of preview reports followed by the posting of data on a Web site other than *Hospital Compare.*

2. Retirement of RHQDAPU Program Measures

a. Considerations in Retiring Quality Measures From the RHQDAPU Program

Unless stated otherwise, we generally retain measures from the current year's RHQDAPU program measure set for subsequent years' measure set. We have previously retired one measure, PN–1: Oxygenation Assessment for Pneumonia, from the RHQDAPU program on the basis of high unvarying performance among hospitals, as measures with very high performance among hospitals present little opportunity for improvement, and do not provide meaningful distinctions in performance for consumers. We also have retired one measure from the program because it no longer "represent[ed] the best clinical practice," as stated under section 1886(b)(3)(B)(viii)(VI) of the Act. In this latter situation, we stated that when there is reason to believe that the continued collection of a measure as it is currently specified raises potential patient safety concerns that it is appropriate for CMS to take immediate action to remove a measure from the RHQDAPU program and not wait for the annual rulemaking cycle. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that we would promptly retire such measures followed by subsequent confirmation of the retirement in the next IPPS rulemaking. When we do so, we will notify hospitals and the public through the usual hospital and QIO communication channels used for the RHQDAPU program, which include memo and email notification and QualityNet Web site articles and postings.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment regarding additional RHQDAPU program measures that should be considered for retirement along with criteria that should be used for retiring measures. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, commenters recommended 11 RHQDAPU program measures for retirement for various reasons (74 FR 43865). Among the criteria suggested by commenters that CMS should consider when determining whether to retire RHQDAPU program measures were: (1) Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made; (2) performance or improvement on a measure does not result in better patient outcomes; (3) a measure does not align with current clinical guidelines or practice; (4) the availability of a more broadly applicable (across settings, populations, or conditions) quality measure for the topic; (5) the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic; (6) the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic; (7) collection and/or public reporting of a measure leads to negative unintended consequences other than patient harm. We agreed with commenters that these criteria should be among those considered in evaluating current RHQDAPU program measures for retirement. We again invite commenters to submit suggestions for additional measure retirement criteria for CMS to consider.

b. Proposed Retirement of Quality Measures Under the RHQDAPU Program for the FY 2011 Payment Determination and Subsequent Years

In the FY 2009 IPPS final rule, for the FY 2010 payment determination we adopted nine measures that were developed by the Agency for Healthcare Research and Quality (AHRQ), and in the FY 2010 IPPS/RY 2010 LTCH PPS we subsequently retained these measures for the FY 2011 payment determination. One of these measures was the AHRQ Mortality for Selected Surgical Procedures Composite, which is comprised of measures from the AHRQ Inpatient Quality Indicator (IQI) measure set. In late June of 2009, following an NQF steering committee evaluation of the AHRQ Mortality for Selected Surgical Procedures composite, the AHRQ issued guidance [6] that this composite is "not recommended for comparative reporting" as specified due to significant evidence gaps, and that these significant evidence gaps are

[6] AHRQ. Guidance on Using the AHRQ QI for Hospital-Level Comparative Reporting. June 2009. *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf.*

unlikely to be addressed with further development or validation work. This guidance is available at: *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf*.

For this reason, we are proposing to retire the Mortality for Selected Procedures Composite from the RHQDAPU program measure set from the RHQDAPU program measure set for the FY 2011 payment determination and for subsequent payment determinations because the measure is not considered suitable for purposes of comparative reporting by the measure developer. We will neither calculate this measure for the FY 2011 payment determination, nor display results for this measure on *Hospital Compare.* We invite comment on our proposal to retire this measure from the RHQDAPU program for the FY 2011 payment determination and for subsequent payment determinations. We also invite commenters to submit suggestions and rationales for retirement of other RHQDAPU program measures.

Set out below are the RHQDAPU program quality measures for the FY 2011 payment determination reflecting our proposed retirement of one measure:

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Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting Proposed Retirement of One Measure
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting Proposed Retirement of One Measure
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2*
	• SCIP-Infection-10: Perioperative Temperature Management*
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care**	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care*
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care*

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3. Proposed Expansion Plan for Quality Measures for the FY 2012, FY 2013, and FY 2014 Payment Determinations

a. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program

In the FY 2009 IPPS final rule (73 FR 48613) and the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43866 through 43869), we acknowledged the data collection burden for hospitals participating in the RHQDAPU program, and reiterated our desire to expand the RHQDAPU program measure set while minimizing burden and seeking to provide alternative mechanisms for data submission for the RHQDAPU program. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also stated that in future expansions and updates to the RHQDAPU program measure set, we would be taking into consideration several important goals. These goals include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program. Specifically, we give priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the RHQDAPU program measure set.

RHQDAPU program measures were initially based solely on a hospital's submission of chart-abstracted quality measure data. However, in recent years we have adopted measures that do not require chart abstraction, including structural and claims-based quality measures which we can calculate using other data sources. This supports our goal of expanding the measures for the RHQDAPU program while minimizing the burden on hospitals and, in particular, without significantly increasing the chart abstraction burden.

In addition to structural and claims-based measures, we previously noted that registries [7] and electronic health records (EHRs) are potential alternative sources of hospital data for the RHQDAPU program. We observed that many hospitals already submit data to and participate in existing registries, and that registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. We envisioned that instead of requiring hospitals to submit the same data to CMS that many hospitals are already submitting to registries, that we would collect the data directly from the registries. This could enable the expansion of the RHQDAPU program measure set without increasing the burden of data collection for those hospitals participating in the registries. We cited as examples of registries actively used by hospitals the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry (with approximately 90 percent participation by cardiac surgery programs), the AHA Stroke Registry (with approximately 1200 hospitals participating), and the American Nursing Association (ANA) Nursing Sensitive Measures Registry (with approximately 1400 hospitals participating). In the FY 2009 IPPS final rule (73 FR 48608 through 48609), we adopted the first RHQDAPU program measure related to registries: Participation in a Systematic Database for Cardiac Surgery. Subsequently, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43870 through 43872), we adopted two additional structural measures of registry participation for the topics of Stroke and Nursing Sensitive Care. We continue to evaluate the feasibility of leveraging registry-based data collection mechanisms for the RHQDAPU program and we are proposing to collect such data for the FY 2013 payment determination.

We also stated our intention to explore mechanisms for data submission using EHRs (73 FR 48614; 74 FR 43866, 43892). Establishing such a system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs will enable us to expand the RHQDAPU program measure set with less cost and burden to hospitals.

In the FY 2009 IPPS final rule, we adopted nine AHRQ measures for the RHQDAPU program, one of which is now proposed for retirement for the FY 2011 payment determination and subsequent payment determinations in this proposed rule. We stated that we would initially calculate the measures using Medicare claims data (73 FR 48608). However, we also stated that we remained interested in using all-payer claims data to calculate them and that we might propose to collect such data in the future. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24169), we invited input and suggestions on how all-payer claims data can be collected and used by CMS to calculate these measures, as well as on additional AHRQ measures that we should consider adopting for future RHQDAPU program payment determinations.

In summary, we will continue to pursue goals regarding the expansion and updating of quality measures under the RHQDAPU program while minimizing burden. We will take into account the public comments we receive on the possible uses of EHRs, registries, and all-payer claims data in the RHQDAPU program. We also will consider the measure selection criteria suggested by various commenters in prioritizing and selecting quality measures for the future." In particular, we are concerned about the lack of progress in reducing the rates of healthcare associated infections that was recently reported in the 2009 National Healthcare Quality Report (*http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf*). For example, the report found that rates of postoperative sepsis increased by 8 percent. It is evident that more attention needs to be paid to ensure health care does not result in avoidable harm and that patients are informed about hospitals' performance. We are soliciting comment on the option to include among our prioritization criteria quality measures that assess performance on healthcare associated infections. Also, while the current and proposed measures cover many aspects of healthcare associated infections, we are soliciting public comment on additional measures that could be added to those hospitals would

[7] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

report and that CMS would make available to the public in order promote improvement in healthcare associated infection rates.

In the past, we have proposed to add new RHQDAPU program measures for one year's payment determination in a given rulemaking cycle. Although in prior years we have identified various measures for future consideration, we have not proposed or finalized measures for the RHQDAPU program beyond those to be collected for the purpose of the next sequential payment determination. In this FY 2011 rulemaking cycle, we are proposing an expansion to the RHQDAPU program that will take place over three payment years, and are proposing to add measures not only for the FY 2012 payment determination, but also for the FY 2013 and FY 2014 payment determinations. To the extent we finalize some or all of these proposed measures this year, we believe that we will be providing greater certainty for hospitals to plan to meet future reporting requirements and implement related quality improvement efforts. We will also have more time to prepare, organize and implement the necessary infrastructure necessary to collect data on the measures and make payment determinations.

Finally, in section V.A.5.(2) of this proposed rule, we discuss a proposal to make RHQDAPU payment determinations beginning with FY 2013 using, in part, a consecutive calendar year of quality measure data. This proposed approach, of synchronizing the quarters for which data on these measures must be submitted during each year with the quarters we will use to make payment determinations, would apply beginning with January 1, 2011 discharges although it would not affect our payment determinations until FY 2013. We invite public comment on the measures and timeframe for their addition to the RHQDAPU program measure set.

b. Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

(1) Proposed Retention of 45 Existing RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

As noted above, we are proposing to retire the AHRQ Mortality for Selected Surgical Procedures Composite for the FY 2011 payment determination. We are proposing that the remaining 45 of the 46 quality measures for the FY 2011 RHQDAPU program payment determination will be used for the FY 2012 RHQDAPU program payment determination. Details regarding data submission requirements are discussed in section V.A.5. of this proposed rule. We invite comment on the proposal to include all FY 2011 measures except for the AHRQ Mortality for Selected Surgical Procedures Composite in the FY 2012 RHQDAPU measure set.

In proposing to retain 45 of the 46 FY 2011 measures, we recognize that we are not significantly reducing the burden for hospitals, since the one measure that we are proposing to remove is a measure that currently is calculated based on Medicare claims. At the same time, we are proposing to expand the measures for the FY 2012 and subsequent years' payment determinations, which may add additional reporting burdens and new focus areas for hospital quality improvement efforts. In view of our concern about the burden of reporting for hospitals, especially when it comes to reporting chart-abstracted measures, another option that we have considered to accommodate the expansion of the measure set is the retirement of additional measures. Specifically, we have considered retiring one or more of those measures suggested by various commenters that were listed in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43865). We noted in that final rule that 11 RHQDAPU program chart-abstracted measures were recommended for retirement by commenters. Seven of these 11 measures were recommended for retirement based on their performance being uniformly high nationwide, with little variability among hospitals. Information on the performance rates for hospitals reporting is available at: *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalNationalLevelPerformance.pdf*. These measures are:

- AMI–1 Aspirin at arrival
- AMI–3 ACEI/ARB for left ventricular systolic dysfunction
- AMI–4 Adult smoking cessation advice/counseling
- AMI–5 Beta-blocker prescribed at discharge
- HF–4 Adult smoking cessation advice/counseling
- PN–4 Adult smoking cessation advice/counseling
- SCIP-Infection-6: Surgery patients with appropriate hair removal

In addition to these "topped out" measures, commenters recommended we retire four additional measures listed below for reasons unrelated to high unvarying performance. These measures are:

- HF–1 Discharge instructions
- PN–3b Blood culture performed before first antibiotic received in hospital
- SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
- SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Reasons given by commenters included the following: (1) Care process measured has weak or no relationship to better outcomes; (2) Collection burden of measure negates or outweighs the benefit of reporting the measure; and (3) Measure perceived to be discordant with current guidelines.

We invite comments on the option to retire one or more of these 11 measures that were suggested for retirement by commenters to the FY 2010 IPPS proposed rule. We note that some of these measures were proposed for electronic reporting under the program for payment incentives for meaningful use of electronic health records (75 FR 1896).

In addition, we are considering an option under which if we propose and finalize measures that are specified to more broadly address a clinical topic, and thus would require hospitals to submit the same data that they are already submitting on more narrowly specified measures that we previously adopted for the RHQDAPU program, we would propose to retire the more narrowly specified measures from the RHQDAPU measure set. An example of this that we are considering would be to retire the current Influenza and Pneumoccocal vaccination measures that apply only to the Pneumonia admission inpatient population (PN–2 Pneumococcal vaccination status; and PN–7 Influenza vaccination status) if we proposed and finalized measures of Influenza and Pneumoccocal vaccination that apply to all inpatients. We invite comments on this option to retire narrowly specified measures in order to accommodate more broadly specified measures on a given topic.

(2) Proposed New Claims-Based Measures

We are proposing to add 10 claims-based measures to the RHQDAPU program measure set for the FY 2012 payment determination: 2 AHRQ Patient Safety Indicators and 8 Hospital Acquired Condition measures. These proposed measures would be calculated using up to three years' of Medicare claims for discharges prior to January 1, 2011. These measures are discussed below.

(A) Proposed AHRQ Patient Safety Indicators

In the FY 2009 IPPS final rule we adopted a number of AHRQ Patient Safety Indicators and Inpatient Quality Indicators for the RHQDAPU program to be calculated using Medicare claims. The addition of these measures to the RHQDAPU program allowed us to expand the RHQDAPU program measure set to include measures of patient safety, in-hospital mortality, adverse events and complications without increasing the data submission burden on hospitals. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we retained these measures for the FY 2011 payment determination. In this proposed rule, we are proposing to retire one of those measures (Mortality for Selected Surgical Procedures Composite) from the RHQDAPU program measure set for the FY 2011 payment determination. For the FY 2012 payment determination, we are proposing to adopt 2 additional Patient Safety Indicators developed by the AHRQ. These are: PSI–11: Post-Operative Respiratory Failure and PSI–12: Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT). Both measures address post-operative complications, a topic that is currently not well represented in the RHQDAPU program measure set. Both measures are NQF-endorsed, and have a Tier 1 evidence rating by AHRQ, the measure developer. Indicators given this level of evidentiary rating by AHRQ have the strongest evidence base, with established evidence in several or most evidentiary areas established by AHRQ, no substantial evidence suggesting that the indicators may not be useful for comparative reporting purposes, and in most cases the indicators have been NQF-endorsed.[8] The specific measures that we are proposing to add are NQF-endorsed, thus reflecting consensus among affected parties, and are deemed appropriate for comparative public reporting by the measure developer. Like the current AHRQ measures in the RHQDAPU program, these indicators are risk-adjusted outcome measures that can be calculated based on existing Medicare claims, placing no additional reporting burden on hospitals while allowing us to expand outcomes measurement in the RHQDAPU program. The specifications for these measures can be found at *http://www.qualityindicators.ahrq.gov/TechnicalSpecs41.htm#PSI41*. We invite comment on our proposal to adopt these two AHRQ Patient Safety Indicators for the FY 2012 payment determination.

(B) Proposed Hospital Acquired Condition (HAC) Measures

Section 1886(d)(4)(D) of the Act required the Secretary to select, in consultation with the Centers for Disease Control and Prevention (CDC), at least two conditions that: (a) Are high cost, high volume, or both; (b) are assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence based guidelines. We currently have 10 categories of Hospital Acquired Conditions (HACs). We refer readers to: section II.F. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218); section II.F. of the FY 2009 IPPS final rule with comment period (73 FR 48474 through 48486); and section II.F. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43782 through 43785) for detailed discussions regarding the selection of the current 10 HAC categories. We refer readers to section II.F. of this proposed rule for additional discussion and our proposals for HAC policy for FY 2011.

We have worked collaboratively with public health and infectious disease professionals from across HHS, including CDC, AHRQ, and the Office of Public Health and Science, to identify and select preventable HACs with input and comment from affected parties. CMS and CDC have also collaborated on the process for hospitals to submit a present on admission (POA) indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications for POA reporting (74 FR 43783).

CMS, CDC and AHRQ held jointly sponsored HAC and POA Listening Sessions (December 17, 2007 and December 18, 2008) to receive input from affected parties, individuals, and organizations regarding the selection and definition of HACs. The adoption of HACs were informed and continue to be informed by feedback received during the listening sessions, as well as through public comment received during the IPPS rulemaking process. In addition to receiving comments regarding the selection of conditions and POA indicator reporting, in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43785), commenters suggested that CMS consider making aggregate POA information publicly available, and providing comparative information as a means of facilitating improvements in preventing the incidence of HACs.

We are proposing to adopt as RHQDAPU measures for the FY 2012 payment determination eight (of 10) current HACs defined in section II.F. of this proposed rule, six of which have been identified by NQF as serious reportable events, and to publicly report these measures as we do other RHQDAPU program measures. These measures are:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing, Injury, Burn, Electric Shock)
- Vascular Catheter-Associated Infection
- Catheter-Associated Urinary Tract Infection (UTI)
- Manifestations of Poor Glycemic Control

We do not believe that it is necessary to propose to adopt the other two current HAC categories as RHQDAPU measures because the topics that they deal with would substantially overlap with other RHQDAPU program measures discussed below that we are proposing to adopt for future payment determinations as chart-abstracted measures (which allows us to collect data on all patients). By contrast, the eight proposed HAC measures are claims-based measures for which we can only (at this time) collect data only on Medicare beneficiaries.

We are proposing to utilize Medicare claims data to calculate measure rates for these eight HACs using the ICD–9–CM codes in conjunction with POA coding of "N" or "U," as defined in IPPS rulemaking. We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218), section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48486), section II.F.6. (74 FR 43782 through 43785) of the FY 2010 IPPS/RY 2010 LTCH PPS final rule, and section II.F. of this proposed rule for detailed discussions regarding the use of the POA indicator in conjunction with ICD–9–CM coding to determine the presence of HACs. We also refer readers to the current ICD–9–CM codes and proposed updates for these eight HAC categories in this proposed rule. We are proposing to use the ICD–9–CM codes in conjunction with the "N" and "U" POA indicators for the HAC categories that will be finalized in the FY 2011 IPPS/RY 2011 LTCH PPS final rule to

[8] *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf.*

calculate the eight HAC measures for the RHQDAPU program.

We believe that these HAC measures reflect consensus among affected parties as required for RHQDAPU program measures by section 1886(b)(3)(B)(viii)(V) of the Act. In addition to meeting the consensus requirement through rulemaking and public comment, Vascular Catheter-Associated Infection and Catheter-Associated UTI are the subject of a quality measure which gained NQF endorsement in August 2009. The remaining six HAC categories have been identified as serious reportable events through the NQF consensus process and have also been selected as HACs through rulemaking and public comment. Data reporting requirements for these measures are provided in section V.A.5. of this proposed rule. We invite comment on our proposal to adopt these eight HAC measures for the FY 2012 payment determination.

(3) Proposed All-Patient Volume Data for Selected MS–DRGs

CMS currently displays volume data for 70 MS–DRGs, 55 of which relate to RHQDAPU program measures on the *Hospital Compare* Web site. However, the volume data currently shown on *Hospital Compare* is based on Medicare claims only. Although we do not consider volume alone to be a quality measure unless volume has been determined to be an indicator of quality, we believe that to the extent all-patient volume data are related to the measures, as they provide context for the quality measures in the inpatient hospital setting, and may assist *Hospital Compare* users in understanding the measure calculations. In general, in implementing RHQDAPU program measures, we have sought where currently possible to measure the care rendered to all patients within a hospital, and not just Medicare patients. For this reason, the chart-abstracted process of care measures we collect and display on *Hospital Compare* are based on the entire inpatient population for the hospital.

We are proposing that hospitals begin submitting as data on measures selected for the RHQDAPU program the all-patient data elements discussed in section V.A.5. of this proposed rule for 55 MS–DRGs displayed on *Hospital Compare* that relate to adopted RHQDAPU program measures. The specific MS–DRGs are listed below. As stated above, we believe that the addition of this data will enable us and Medicare beneficiaries to better understand and evaluate the quality of care provided by hospitals with respect to both the chart-abstracted and claims-based measures. We intend to publicly display this volume data along with the corresponding measure results on *Hospital Compare.* Hospitals would begin reporting these data once annually beginning with January 1, 2011 discharges by submitting the all-patient data elements needed to calculate MS–DRG volume to QualityNet so we can determine the volume of cases treated by a hospital for the 55 MS–DRGs currently displayed on *Hospital Compare.* Rather than require hospitals to group their all-patient claims data by MS–DRG category themselves, CMS would use the data to be submitted by hospitals to group the data.We invite comments on this proposal.

We also invite comment on an alternative that hospitals submit all-patient volume data based upon specific ICD–9–CM codes related to the proposed MS–DRGs rather than all data necessary to calculate the MS–DRGs.

The proposed RHQDAPU measure set for the FY 2012 payment determination is listed below:

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 11: Post Operative Respiratory Failure *
	• PSI 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
Hospital Acquired Condition Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	• Vascular Catheter-Associated Infection*
	• Catheter-Associated Urinary Tract Infection (UTI)*
	• Manifestations of Poor Glycemic Control*
All-Patient Volume Data for Selected MS-DRGs *	
	MS-DRGs: 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459; 461; 462; 466; 467; 468; 469; 470; 471; 472; 477; 478; 490; 507; 515; 656; 657; 658; 659; 668; 673; 674; 675; 713; 743; 748 *

* Proposed for FY 2012 payment determination

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We invite comment on these proposed measures for the FY 2012 payment determination.

c. Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination

(1) Proposed Retention of FY 2012 Payment Determination Measures for the FY 2013 Payment Determination

We generally propose to retain RHQDAPU program measures from one year to the next. Consistent with this approach, we are proposing to retain all of the proposed measures for the FY 2012 RHQDAPU payment determination, if finalized, for the FY 2013 payment determination. We invite public comment on this proposal.

(2) Proposed New Chart-Abstracted Measure for the FY 2013 Payment Determination

We are proposing to add one new chart-abstracted measure for the FY 2013 payment determination—AMI-statin at discharge. This measure is similar to the NQF-endorsed stroke measure "Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication" (NQF #0439), only specified for the AMI population. Current scientific evidence supports the continuation of statins more strongly for AMI patients than for stroke patients. Several randomized clinical trials have proven the benefits of statin drugs (also known as HMG Co-A reductase inhibitors) in reducing the risk of death and recurrent cardiovascular events in a broad range of patients with established cardiovascular disease, including those with prior myocardial infarction. Current ACC/AHA guidelines place a strong emphasis on the initiation or maintenance of statin drugs for patients hospitalized with AMI, particularly those with LDL-cholesterol levels at or above 100 mg/dL. As a result of the strength of the evidence and guideline support, the ACC/AHA has developed a performance measure to assess this aspect of care for AMI patients.

Because statins are generally well-tolerated, most AMI patients are appropriate candidates for this therapy. As a result of this clinical evidence, the NQF has been asked to review whether it should broaden the current endorsed measure specification to include the AMI population. This ad hoc review is occurring now and is expected to be completed prior to publication of the FY 2011 IPPS/LTCH PPS final rule. Information on this project can be found at: *http://www.qualityforum.org/Projects/a-b/Ad_Hoc_Reviews/Statin_Medication/Ad_Hoc_Review__Discharged_on_Statin.aspx.* We will decide whether to finalize this measure based on whether it achieves NQF endorsement and public comments. We believe that minimal additional burden would result from adoption of this measure into the RHQDAPU program because the AMI population that is the focus of this measure is already part of data collection efforts for RHQDAPU, and very few additional data elements would be needed to be abstracted for the proposed new measure on this existing measurement population. We proposed that hospitals would begin submission of data for the AMI-statin at discharge measure beginning with January 1, 2011 dischares for the RHQDAPU 2013 payment determination.

(3) Proposed New Healthcare Associated Infection (HAI) Measures for the FY 2013 Payment Determination

In the FY 2009 and FY 2010 IPPS rulemakings, we listed several Healthcare Associated Infection (HAI) measures as being under consideration for future adoption. Commenters to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule supported the HAI measures that were listed as being under consideration for the future and encouraged CMS to consider others as well (74 FR 43876). For the measure set to be used for the FY 2013 payment determination, we are proposing to adopt two new measures of Healthcare Acquired Infections that are currently being collected by the CDC via the National Healthcare Safety Network (NHSN). These measures are: (1) Central Line Associated Blood Stream Infection (NQF #0139) and (2) Surgical Site Infection (NQF #0299).

The NHSN is a secure, Internet-based surveillance system maintained and managed by the CDC, and can be

utilized by all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. The NHSN enables healthcare facilities to collect and use data about HAIs, adherence to clinical practices known to prevent HAIs, the incidence or prevalence of multidrug-resistant organisms within their organizations, and other adverse events. Some States use NHSN as a means for healthcare facilities to submit data on HAIs mandated through their specific State legislation. Currently, 21 States require hospitals to report HAIs using NHSN, and CDC supports more than 2000 hospitals that are using NHSN.[9]

Both the Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure are NQF-endorsed, and therefore meet the statutory requirement for measure selection of reflecting consensus among affected parties. The measures address HAIs, a topic area widely acknowledged by the HHS, IOM, the National Priorities Partnership and others as a high priority requiring measurement and improvement. HAIs are among the leading causes of death in the United States. CDC estimates that as many as 2 million infections are acquired each year in hospitals and result in approximately 90,000 deaths per year.[10] It is estimated that more Americans die each year from HAIs than from auto accidents and homicides combined. HAIs not only put the patient at risk, but also increase the days of hospitalization required for patients and add considerable health care costs.

HAIs are largely preventable through interventions such as better hygiene and advanced scientifically tested techniques for surgical patients. Therefore, many health care consumers and organizations are calling for public disclosure of HAIs, arguing that public reporting of HAI rates provides the information health care consumers need to choose the safest hospitals, and gives hospitals an incentive to improve infection control efforts. Both of the measures we are proposing to add for the FY 2013 payment determination are NQF-endorsed, and are currently collected using the NHSN as part of State-mandated reporting and surveillance requirements for hospitals. NHSN data collection occurs via a Web-based tool hosted by CDC provided free of charge to hospitals. Additionally, data submission for these measures through EHRs may be possible in the near future.

(A) Central Line Associated Blood Stream Infection

This HAI measure assesses the rate of laboratory-confirmed cases of bloodstream infection or clinical sepsis among ICU patients. It was endorsed by the NQF in 2004 and was adopted by the HQA in 2007. The measure can be stratified by the type of ICU.

(B) Surgical Site Infection

This HAI measure assesses the number of NHSN-defined operative procedures with a surgical site infection (deep incisional or organ space) within 30 days, or 1 year if an implant is in place. Infections are identified on original admission or upon readmission to the facility of original operative procedure within the relevant time frame (30 days for no implants; within 1 year for implants). The measure can be stratified by procedure type or risk factors. This measure was NQF-endorsed in 2007 and was adopted by the HQA in 2008.

We invite comment on our proposal to adopt these two HAI measures into the RHQDAPU program for the FY 2013 payment determination. Collection of these measures would begin with January 1, 2011 discharges for the FY 2013 payment determination. We are proposing that hospitals use the NHSN infrastructure to report the measures for RHQDAPU program purposes. The proposed reporting mechanism for these HAI measures is discussed in greater detail in section V.A.5. of this proposed rule.

(4) Proposed New Registry-Based Measures

For the FY 2013 payment determination, we are proposing that hospitals choose one of the following four proposed measure topics: (1) Implantable Cardioverter Defibrillator (ICD) Complications; (2) Cardiac Surgery; (3) Stroke; or (4) Nursing-Sensitive Care. With respect to the proposed measure topic selected by a hospital, we are proposing that the hospital report data on the proposed measure(s) applicable to the measure topic (discussed below) to a qualified registry for the specific topic, and direct the registry to both calculate the measure results for the hospital and release those results (along with the numerator/denominator information and exclusion information) to CMS for the RHQDAPU program. We are proposing that hospitals begin submitting data to the qualified registry of its choosing for discharges on or after January 1, 2011, and we intend to release a list of qualified registries before that date. In section V.A.13. of this proposed rule, we specify the self-nomination process we are proposing to use to qualify registries for each proposed registry-based measure topic. Proposed procedural and submission requirements for the proposed registry-based measures are discussed in section V.A.5. of this proposed rule. Below is a discussion of the proposed registry-based measure topics and specific registry-based measures that fall within each topic that we are proposing to add to the RHQDAPU program for the FY 2013 payment determination.

(A) Proposed Implantable Cardioverter Defibrillator (ICD) Complications Registry-Based Topic and Measure

Implantable Cardioverter Defibrillators (ICDs) reduce the risk of sudden cardiac death for select high risk patients, and the number of patients undergoing ICD implantation increased from 5,600 in 1990 to 108,680 by 2005.[11] ICD implantation is an expensive procedure performed on patients with advanced cardiovascular disease and, often, significant comorbidities. Despite improvements in technology and increasing experience with device implantation, the procedure carries a significant risk of complications,[12] which in turn increases its cost, the patient's length of stay, and the patient's risk of mortality.[13] In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43873 through 43875), our list of potential future quality measures under consideration included a measure of ICD complications. This measure is a risk-adjusted complication and mortality rate following implantation of ICDs in Medicare Fee for Service (FFS) patients at least 65 years of age, with complication specific outcome time frames. The measure (NQF #OT1–007–09) is currently undergoing NQF review

[9] *http://www.cdc.gov/nhsn/.*

[10] McKibben L, Horan T Guidance on public reporting of healthcare-associated infections: recommendations of the Healthcare Infection Control Practices Advisory Committee. AJIC 2005;33:217–26.

[11] Brown, D.W., Croft, J.B., et al. (2008). "Trends in Hospitalizations for the Implantation of Cardioverter-Defibrillators in the United States, 1990–2005." *American Journal of Cardiology* 101 (12): 1753–1755.

[12] Hammill S and Curtis J. Publicly Reporting Implantable Cardioverter Defibrillator Outcomes—Grading the Report Card. Circ Arrhythmia Electrophysiol. 2008;1:235–237).

[13] Al-Khatib SM, Greiner MA, Peterson ED, Hernandez AF, Schulman KA, Curtis LH. Patient and Implanting Physician Factors Associated With Mortality and Complications After Implantable Cardioverter-Defibrillator Implantation, 2002–2005. Circ Arrhythmia Electrophysiol. 2008;1:240–249.

under Phase 1 of a call for Patient Outcome Measures initiated in Fall of 2009. We are proposing to add the ICD complications topic and measure to the RHQDAPU measure set for collection beginning with January 1, 2011 discharges for the FY 2013 RHQDAPU payment determination pending NQF endorsement. We anticipate that a final endorsement decision will occur in the fall of 2010, after publication of the FY 2011 IPPS/LTCH PPS final rule. Therefore, the decision whether to finalize this measure for the FY 2013 payment determination will be made in the CY 2011OPPS/ASC final rule with comment period.

The proposed ICD complications measure was developed based upon data submitted to the American College of Cardiology-National Cardiovascular Data Registry's (ACC–NCDR) ICD registry, and data from that registry has been linked with CMS administrative claims data used to identify procedural complications. For this proposed measure, the measured outcome for each ICD index admission is one or more complications or mortality within 30 or 90 days (depending on the complication) following ICD implantation. Complications are counted in the measure only if they occur during a hospital admission. Complications measured for 30 days include: (1) Pneumothorax or hemothorax plus a chest tube; (2) Hematoma plus a blood transfusion or evacuation; (3) Cardiac tamponade or pericardiocentesis; and (4) Death. Complications measured for 90 days include: (5) Mechanical complications requiring a system revision; (6) Device related infection; and (7) Additional ICD implantation.

To comply with a January 2005 National Coverage Determination for ICDs for primary prevention, all hospitals in which ICD procedures are performed are currently submitting to the ACC–NCDR ICD registry patient information needed for us to determine whether the procedure was reasonable and necessary. This requirement is documented in section 20.4 of the following Medicare National Coverage Determination Manual: *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf*. For purposes of the 2005 National Coverage Determination, we require that hospitals submit data to the ACC–NCDR ICD registry for primary prevention patients only but do not require hospitals to submit data on patients undergoing ICD implantation for secondary prevention. However, the ICD complication measure as submitted to the NQF for endorsement is specified such that it includes all ICD patients, regardless of whether they receive an ICD for the primary or secondary prevention of sudden cardiac death.

Therefore, hospitals that choose this registry-based measure topic for the RHQDAPU program would submit data on the ICD complications measure for both primary and secondary prevention patients to the qualified registry. For risk adjustment, data matching, and secondary prevention population identification purposes, we are proposing that hospitals also submit to the qualified ICD complications registry an additional 11 data elements not currently required under the NCD in order for the measure to be calculated for RHQDAPU program purposes.

In sum, we are proposing to add the ICD complications measure topic as one of four proposed measure topics that hospitals can choose from to submit required data elements to a qualified registry for the FY 2013 RHQDAPU payment determination. The only measure that we are proposing to include in this proposed topic at this time would be the ICD complications measure. Because the ICD complications measure is a risk-adjusted outcome measure, it is necessary that all data for the measure be collected by a single qualified registry in order for that registry to be able to accurately calculate the risk adjustment model and subsequent measure results. Therefore, we are proposing to qualify one registry for this topic. Proposed registry qualification criteria are discussed in section V.A.13. of this proposed rule. We note that the ACC–NCDR ICD registry has already been qualified to receive and transmit data to CMS for a Medicare National Coverage Determination, and is currently the only registry to which hospitals submit data for this NCD. However, this would not preclude another registry from self-nominating to become a qualified registry for this proposed topic for the RHQDAPU program. Because the ICD complication measure is a risk adjusted measure, it requires that all data be collected at a single repository for calculation of the measure. Therefore, we anticipate qualifying a single registry to collect all of the data for the proposed ICD complications registry-based topic.

(B) Proposed Stroke Registry-Based Topic and Measures

We proposed to add five stroke measures to the RHQDAPU measure set in the FY 2009 IPPS proposed rule (73 FR 23648). We indicated that we would again consider these measures once NQF reviewed and endorsed the measures. Since that time, eight stroke measures received NQF endorsement in July of 2008, and in the FY 2010 IPPS/RY 2010 LTCH PPS final rule we included these measures in the list of potential future measures. We also included these measures in the preview section of the Specifications Manual, and have worked with the Office of the National Coordinator for Health Information Technology (ONC) and its partners to create a set of electronic specifications for these measures to facilitate collection through EHRs.

We are also aware that a number of hospitals are already submitting these measures to registries, and in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we finalized a structural measure of participation in a systematic clinical database registry for stroke care. Stroke is a topic of great relevance to the Medicare population due to its impact on morbidity and mortality, and is an area of great potential improvement for hospitals. Commenters on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule expressed support for these measures, indicating that they accurately measure evidence-based care of the stroke patient to minimize secondary strokes and other complications, are widely recognized, and have great potential for quality improvement (74 FR 43875).

Therefore, we are proposing to include the following eight measures in the Stroke registry-based topic:

PROPOSED MEASURES FOR STROKE REGISTRY-BASED TOPIC

STK–1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke (NQF #0434).	Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.
STK–2: Ischemic stroke patients discharged on antithrombotic therapy. (NQF #0435).	Patients with an ischemic stroke prescribed antithrombotic therapy at discharge.
STK–3: Anticoagulation therapy for atrial fibrillation/flutter. (NQF #0436).	Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.

PROPOSED MEASURES FOR STROKE REGISTRY-BASED TOPIC—Continued

STK–4: Thrombolytic Therapy for Acute ischemic stroke patients. (NQF #0437).	Acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.
STK–5: Antithrombotic therapy by the end of hospital day two. (NQF #0438).	Patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.
STK–6: Discharged on statin medication. (NQF #0439).	Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
STK–8: Stroke education. (NQF #0440)	Patients with ischemic or hemorrhagic stroke or their caregivers who were given education or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency.
STK–10: Assessed for rehabilitation services. (NQF #0441).	Patients with an ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services.

We are proposing to add the stroke registry-based topic, which would include these eight registry-based stroke measures, to the RHQDAPU program measure set as one of the four proposed measure topics that hospitals can choose from to submit data to a qualified registry for the FY 2013 payment determination beginning with January 1, 2011 discharges. We invite comment on the measures as well as the timing of their addition to the RHQDAPU measure set.

(C) Proposed Nursing Sensitive Care Registry-Based Topic and Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we indicated that we were considering adopting a number of nursing-sensitive care measures for future RHQDAPU program payment determinations. Also in that rule, we adopted a structural measure of participation in a registry for nursing-sensitive care, under which hospitals submit data directly to the QIO Clinical Warehouse.

For the FY 2013 payment determination, we are proposing to add a nursing sensitive care registry-based topic to the RHQDAPU measure set, which would include the eight nursing-sensitive care measures listed below. All of the proposed nursing sensitive measures are NQF-endorsed. Hospitals selecting this topic would begin reporting data on the eight proposed nursing-sensitive care registry-based measures to a qualified nursing-sensitive care registry beginning with January 1, 2011 discharges. Hospitals would continue reporting the nursing-sensitive care structural measure previously adopted for the RHQDAPU program directly to the QIO Clinical Warehouse.

We invite comment on the proposed addition of a nursing sensitive care registry-based topic, which would include 8 proposed nursing sensitive care measures, as well as the timing of this addition to the RHQDAPU program for the FY 2013 payment determination.

PROPOSED MEASURES FOR NURSING SENSITIVE CARE REGISTRY-BASED TOPIC

Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month. (NQF #0141).
Falls with Injury: All documented patient falls with an injury level of minor or greater. (NQF #0202).
Pressure Ulcer Prevalence (NQF #0201).
Restraint Prevalence (vest and limb) (NQF #0203).
Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency (NQF #0204).
Hours per patient day worked by RN, LPN, and UAP (NQF #0205).
Practice Environment Scale-Nursing Work Index (NQF #0206).
Voluntary turnover for RN, APN, LPN, UAP (NQF #0207).

(D) Proposed Cardiac Surgery Registry-Based Topic and Measures

We have previously proposed to add several measures on the topic of cardiac surgery to the RHQDAPU measure set (73 FR 48608), and have also listed a set of NQF-endorsed cardiac surgery measures in prior rules as being under consideration for future adoption (74 FR 43874). We also adopted a structural measure of cardiac surgery participation in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. Cardiac surgery procedures carry a significant risk of morbidity and mortality. We believe that the nationwide public reporting of the 15 proposed cardiac surgery registry-based measures would provide highly meaningful information for Medicare beneficiaries because they address procedures widely performed on Medicare beneficiaries. Analysis of the structural measure data we have received from hospitals indicates that nearly 90 percent of hospitals performing these procedures already report these data to clinical registries. Therefore, if we adopt this proposed registry-based topic, a hospital would not face any additional data submission burden if it chooses this registry-based topic for purposes of the FY 2013 payment determination and the registry to which it already submits data is qualified for this proposed topic.

For the FY 2013 payment determination, we are proposing to include 15 cardiac surgery registry-based measures in the cardiac surgery registry-based measure topic. These proposed registry-based measures are listed below, and hospitals would submit data on these measures to a qualified registry for the cardiac surgery registry-based topic. Hospitals would continue submitting data for the cardiac surgery structural measure previously adopted for the RHQDAPU program directly to the QIO Clinical Warehouse.

PROPOSED MEASURES FOR PROPOSED CARDIAC SURGERY REGISTRY-BASED TOPIC

Post-operative Renal Failure (NQF# 0114).
Surgical Re-exploration (NQF# 0115).
Anti-Platelet Medication at Discharge (NQF# 0116).
Beta Blockade at Discharge (NQF# 0117).
Anti-Lipid Treatment Discharge (NQF# 0118).
Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG (NQF# 0119)*.
Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) (NQF# 0120)*.
Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR) (NQF# 0121)*.
Risk-Adjusted Operative Mortality MVR+CABG Surgery (NQF# 0122)*.
Risk-Adjusted Operative Mortality for AVR+CABG (NQF# 0123)*.
Pre-Operative Beta Blockade (NQF# 0127).
Duration of Prophylaxis for Cardiac Surgery Patients (NQF# 0128).
Prolonged Intubation (ventilation) (NQF# 0129).
Deep Sternal Wound Infection Rate (NQF# 0130).
Stroke/Cerebrovascular Accident (NQF# 0131).

* Requires risk adjustment.

Because these measures were endorsed by the NQF in May of 2007, they meet the statutory requirement of reflecting consensus among affected parties. Hospitals selecting this topic would begin submitting data on the proposed measures to a qualified cardiac surgery registry beginning with January 1, 2011 discharges. We note that five of these measures (indicated with an asterisk in the table above) must be risk-adjusted in order to be calculated properly. Therefore, the data needed to calculate these measures must be collected by a single registry. While the remaining measures do not require risk adjustment, we believe it may be overly burdensome for hospitals to submit data for this topic to more than one registry. For this reason, we anticipate qualifying a single registry to collect all of the data for the proposed cardiac surgery registry-based topic. We invite comment on this proposal.

Set out below are the RHQDAPU program topics and quality measures we are proposing to adopt for the FY 2013 payment determination:

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
	• AMI-Statin at Discharge **
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI – 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Healthcare Associated Infections **	
	• Central Line Associated Bloodstream Infection **
	• Surgical Site Infection **
ICD Complications -- Registry Based **	
	• ICD Complications and Mortality **
Stroke -- Registry Based **	
	• STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	ischemic or hemorrhagic stroke **
	• STK-2: Ischemic stroke patients discharged on antithrombotic therapy.**
	• STK-3: Anticoagulation therapy for atrial fibrillation/flutter.**
	• STK-4: Thrombolytic Therapy for Acute ischemic stroke patients.**
	• STK-5: Antithrombotic therapy by the end of hospital day two.**
	• STK-6: Discharged on statin medication.**
	• STK-8: Stroke education. **
	• STK-10: Assessed for rehabilitation services.**
Nursing Sensitive Care – Registry Based **	
	• Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month.**
	• Falls with Injury: All documented patient falls with an injury level of minor or greater.**
	• Pressure Ulcer Prevalence**
	• Restraint Prevalence (vest and limb)**
	• Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency**
	• Hours per patient day worked by RN, LPN, and UAP**
	• Practice Environment Scale-Nursing Work Index**
	• Voluntary turnover for RN, APN, LPN, UAP**
Cardiac Surgery – Registry Based **	
	• Post-operative Renal Failure**
	• Surgical Re-exploration**
	• Anti-Platelet Medication at Discharge**
	• Beta Blockade at Discharge**
	• Anti-Lipid Treatment Discharge**
	• Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG**
	• Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)**
	• Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR)**
	• Risk-Adjusted Operative Mortality MVR+CABG Surgery**
	• Risk-Adjusted Operative Mortality for AVR+CABG**
	• Pre-Operative Beta Blockade**
	• Duration of Prophylaxis for Cardiac Surgery Patients**
	• Prolonged Intubation (ventilation)**
	• Deep Sternal Wound Infection Rate**
	• Stroke/Cerebrovascular Accident**
HAC Prevalence Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock) *
	• Vascular Catheter-Associated Infections *
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control *
All-Patient Volume Data for Selected MS-DRGs *	
	• **MS-DRGs:** 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459;461; 462; 466; 467; 468; 469; 470; 471; 472;477; 478;490;507;515;656; 657; 658; 659; 668; 673; 674; 675; 713;; 743; 748 *

* Proposed for FY 2012 payment determination.
** Proposed for FY 2013 payment determination.

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d. Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination

(1) Proposed Retention of FY 2013 Payment Determination Measures for the FY 2014 Payment Determination

We are proposing to retain all of the measures adopted for the FY 2013 payment determination for the FY 2014 payment determination. Collection of data for these measures would begin with January 1, 2012 discharges. We invite comment on this proposal.

(2) Proposed New Chart-Abstracted Measures for the FY 2014 Payment Determination

We also are proposing to add the following 4 new chart-abstracted measures to the RHQDAPU program measure set for the FY 2014 payment determination: (1) ED [Emergency Department]Throughput—Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497); (2) ED Throughput—Median time from emergency department arrival to ED departure for admitted patients (NQF #0495); (3) Global Flu Immunization; and (4) Global Pneumonia Immunization. In proposing to adopt these chart-abstracted measures, we recognize that we are proposing to increase the chart-abstraction burden on hospitals with respect to the RHQDAPU program. However, the burden associated with the proposed immunization measures for all inpatients could be counterbalanced by future retirement of the two current immunization measures that apply only to pneumonia inpatients. This measure retirement option is discussed earlier in section V.A.2. of this proposed rule. Furthermore, we note that the ED–Throughput measures have been specified for EHR-based collection, which may also serve to reduce burden associated with these measures in the future.

(A) Emergency Department (ED)-Throughput Measures

The two ED-Throughput measures we are proposing for the FY 2014 payment determination are: (1) Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status; and (2) Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

The ED-Throughput measures reflect not only the processes of care that occur while the patient is in the emergency department, but also reflect the coordination of care, communication, and efficiency of service provision beyond the walls of the emergency department. These measures have been NQF-endorsed (NQF #0497 and #0495) and adopted by HQA. Specifications for these measures are available in the preview section of the current Specifications Manual available on QualityNet.

These measures also address ED overcrowding, which the IOM identified as a major quality issue. Reducing the time patients remain in the ED can improve access to treatment and increase the quality of care, and capability of the hospital to provide adequate treatment to patients. ED overcrowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. Finally, when EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

(B) Global Immunization Measures

For the FY 2014 payment determination, we are proposing to adopt two global immunization measures: (1) Pneumoccocal Immunization; and (2) Influenza Immunization. Increasing influenza (flu) and pneumonia vaccination could reduce unnecessary hospitalizations and secondary complications particularly among high risk populations such as the elderly. About 36,000 adults die annually and over 200,000 are hospitalized for flu-related causes. Older adults are more vulnerable, and adults over 65 comprise about 90 percent of flu-related deaths. Vaccinations can significantly reduce the number of flu related illnesses and deaths. The measures we are proposing were endorsed by the NQF as part of a

consensus development project titled "National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations" which concluded in 2008. This project resulted in the endorsement of immunization measures that reflect current consensus among affected parties that standard measure specifications for influenza and pneumonia immunization should be broadly applicable across conditions, populations, and care settings. The technical specifications for these global measures will be available for preview in the Specifications Manual published in April 2010. The difference between these proposed immunization measures, and the two immunization measures that are currently part of the RHQDAPU program is that the current measures only apply to inpatients admitted for pneumonia, whereas the proposed measures apply to all inpatients regardless of admission diagnosis.

We are proposing to adopt these four chart-abstracted measures into the RHQDAPU program measure set for the FY 2014 payment determination. Data submission for these measures would begin with January 1, 2012 discharges. We invite comment on these proposed measures as well as the proposed timing of their addition to the RHQDAPU program for the FY 2014 payment determination. The complete list of proposed quality measures for the FY 2014 payment determination is set out below.

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
	• AMI Statin at Discharge **
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI -06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI –12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
Healthcare Associated Infections **	
	• Central Line Associated Bloodstream Infection **
	• Surgical Site Infection **
ICD Complications -- Registry–Based **	
	• ICD Complications and Mortality **
Stroke -- Registry-Based **	
	• STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke. **
	• STK-2: Ischemic stroke patients discharged on antithrombotic therapy. **
	• STK-3: Anticoagulation therapy for atrial fibrillation/flutter. **
	• STK-4: Thrombolytic Therapy for Acute ischemic stroke patients. **
	• STK-5: Antithrombotic therapy by the end of hospital day two. **
	• STK-6: Discharged on statin medication. **
	• STK-8: Stroke education. **
	• STK-10: Assessed for rehabilitation services. **
Nursing Sensitive Care – Registry-Based **	
	• Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month **
	• Falls with Injury: All documented patient falls with an injury level of minor or greater **
	• Pressure Ulcer Prevalence **
	• Restraint Prevalence (vest and limb) **
	• Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency **
	• Hours per patient day worked by RN, LPN, and UAP **
	• Practice Environment Scale-Nursing Work Index **
	• Voluntary turnover for RN, APN, LPN, UAP **
Cardiac Surgery – Registry–Based **	
	• Post-operative Renal Failure **
	• Surgical Re-exploration **
	• Anti-Platelet Medication at Discharge **
	• Beta Blockade at Discharge **
	• Anti-Lipid Treatment Discharge **
	• Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG **
	• Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) **
	• Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR) **
	• Risk-Adjusted Operative Mortality MVR+CABG Surgery **
	• Risk-Adjusted Operative Mortality for AVR+CABG **
	• Pre-Operative Beta Blockade **

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
	• Duration of Prophylaxis for Cardiac Surgery Patients **
	• Prolonged Intubation (ventilation) **
	• Deep Sternal Wound Infection Rate **
	• Stroke/Cerebrovascular Accident **
HAC Prevalence Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock) *
	• Vascular Catheter-Associated Infection *
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control *
All-Patient Volume Data for Selected MS-DRGs *	
	• **MS-DRGs:** 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459;461; 462; 466; 467; 468; 469; 470; 471; 472;477; 478;490;507;515;656; 657; 658; 659; 668; 673; 674; 675; 713; 743; 748 *
Emergency Department Throughput ***	
	• Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. ***
	• Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ***
Global Immunization Measures ***	
	• Immunization for Influenza ***
	• Immunization for Pneumonia ***

*Proposed for FY 2012 payment determination.
**Proposed for FY 2013 payment determination.
*** Proposed for FY 2014 payment determination.

4. Possible New Quality Measures for Future Years

We are inviting public comment on the following quality measures and topics set out below that we are considering for the future. We also are seeking suggestions and rationales to support the adoption of measures and topics that are not included in this list for the RHQDAPU program.

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Surgical Safety	Surgical checklist use for surgical procedures
Complications	Lower Extremity Bypass Complications
PCI Readmission	30-day risk-standardized readmission rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older.
PCI Mortality	30-day risk-standardized mortality rate following PCI for STEMI/shock patients.
PCI Mortality	30-day risk-standardized mortality rate following PCI for non-STEMI/non-shock patients.
VTE	VTE-1: Venous Thromboembolism Prophylaxis
VTE	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
VTE	VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
VTE	VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
VTE	VTE-5: Venous Thromboembolism Discharge Instructions
VTE	VTE-6: Incidence of Potentially-Preventable Venous Thromboembolism.
SCIP	Short Half-Life prophylactic administered preoperatively redosed within 4 hours after preoperative dose
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge ED Visit Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Evaluation and Management Service Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge ED Visit Rate
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Evaluation and Management Service Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Care Transition Composite Measure
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge ED Visit Rate
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Evaluation and Management Service Measure

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Care Transition Composite Measure
Healthcare Associated Infections	Ventilator Associated Pneumonia
Healthcare Associated Infections	Multidrug-resistant organism (MDRO) infection
Healthcare Associated Infections	Clostridium Difficile Associated Diseases (CDAD)
Health Care Personnel Immunization	Influenza Vaccination for Healthcare Personnel
Cardiac Rehabilitation Referral	Cardiac Rehabilitation Referral for AMI, HF, Cardiac Surgery
End of Life Care	Appropriate Pain Management
Serious Reportable Events	NQF approved Serious Reportable Events

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5. Form, Manner, and Timing of Quality Data Submission

Sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit quality data in a form and manner, and at a time, specified by the Secretary. The data submission requirements, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at: *http://www.QualityNet.org/*. CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods.

Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (*https://www.QualityNet.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act (HIPAA) requirements for security of protected health information.

a. Proposed RHQDAPU Program Requirements for FY 2012, FY 2013, and FY 2014

(1) Procedural Requirements for the FY 2012, FY 2013, and FY 2014 Payment Determinations

For the FY 2012, FY 2013, and FY 2014 payment determination, we are proposing that the following procedures would apply to hospitals participating in the RHQDAPU program. These procedures are, for the most part, the same as the procedures that apply to the FY 2011 payment determination. We identify below where we are proposing to modify a procedure.

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.
- Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*http://www.QualityNet.org*).
- Complete a Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in the RHQDAPU program for the first time must complete a revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form (Notice of Participation form) that includes the name and address of each hospital campus that shares the same CMS Certification Number (CCN). We will revise the Notice of Participation form as needed and will provide appropriate notification of any revisions to hospitals and QIOs through the routine RHQDAPU communication channels which include memo and e-mail notification and QualityNet Web site articles and postings.

We are proposing that, consistent with our policy for the FY 2011 payment determination, any hospital that receives a new CCN on or after October 15, 2009 (including new subsection (d) hospitals and hospitals that have merged) that wishes to participate in the RHQDAPU program and has not otherwise submitted a Notice of Participation form using the new CCN must submit a completed Notice of Participation form no later than 180 days from the date identified as the open date (that is, the Medicare acceptance date) on the approved CMS Online System Certification and Reporting (OSCAR) system to participate in the RHQDAPU program for FY 2012 and future years. We believe that this deadline will give these hospitals a sufficient amount of time to get their operations up and running while simultaneously providing CMS with clarity regarding whether they intend to participate in the RHQDAPU program for FY 2012.

(2) Synchronization of RHQDAPU Program Data Submission and Validation Quarters With Quarters Used To Make Payment Determinations

Currently we determine, in part, whether a hospital has met the RHQDAPU program requirements for a given fiscal year by looking at whether the hospital properly submitted data with respect to a number of quarterly discharge periods. However, the quarters that we look at for HCAHPS data, chart-abstracted RHQDAPU program measures, and structural measures may not be the same for a single payment determination. For example, for the FY 2011 payment

determination, we looked at discharge data submitted by hospitals from 4th quarter 2008 through 3rd quarter 2009 for AMI, HF, and PN chart-abstracted RHQDAPU program measures, 1st quarter 2010 for the newly added SCIP Infection 9 and 10 measures, April 2008 through March 2009 data for HCAHPS, and January 1, 2010 through June 30, 2010 data for structural measures.

This lack of synchronization has developed because we have generally made payment decisions using the four earliest occurring discharge quarters for each measure topic that we did not include in a previous year's payment determination, and we have not synchronized when hospitals must begin reporting data on new measures.

Starting with the FY 2013 payment determination, we are proposing to determine whether the hospital meets the data submission requirement for quality measure data by looking at whether the hospital properly submitted data on the applicable measures during the same quarterly discharge periods. Specifically, the quarterly discharge periods that will apply to a particular payment determination will be the four quarters that occur within a calendar year. In other words, beginning with the FY 2013 payment determination, we will look at whether the hospital properly submitted data for quality measure data for the four calendar year quarters of CY 2011.

With respect to our requirement that hospital data be successfully validated in order for the hospital to earn the full payment update for a given fiscal year, we are also proposing, beginning with the FY 2013 payment determination, to validate four discharge quarters, but the quarters will be the 4th calendar quarter of the calendar year that occurs two years before the payment determination and the first 3 calendar quarters of the following calendar year. Thus, for the FY 2013 payment determination, we will validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011. We believe this is appropriate given the time required for the validation abstraction and appeal process.

This proposed synchronization will give us a more complete picture of the quality of care provided by a hospital during a given time period, thus enabling us to link that quality of care to the applicable RHQDAPU payment determination. In addition, this proposal will provide clarity to hospitals regarding what data we will look at to make payment determinations for a given fiscal year. We believe that this synchronization will also assist us to more effectively implement the RHQDAPU program because we will be able to achieve operational consistency regarding what data applies to what payment determination. Further, we believe that this proposal may assist the agency in implementing Hospital Value-Based Purchasing as authorized by the Patient Protection and Affordable Care Act, Public Law 111–148, because it will improve the link between quality, as measured during a single period of time, and the payment amounts provided to hospitals. For example, under our proposal, the HCAHPS patient experience of care measure and chart-abstracted measures for a single set of discharge quarters will be used together for a single payment determination. Finally, we believe that this proposal will improve hospitals' ability to implement quality improvement strategies that affect RHQDAPU program measures and their quality of care.

We will post a table outlining the discharge quarters that will be used to make each fiscal year payment determination no later than September 15th annually on the QualityNet Web site (*http://www.QualityNet.org*). We welcome comments on this proposal.

(3) Proposed HCAHPS Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

We are proposing that, for the FY 2012, FY 2013 and FY 2014 payment determinations, except as noted below, the RHQDAPU program HCAHPS requirements we adopted for FY 2011 would continue to apply. Under these requirements, a hospital must continuously collect and submit HCAHPS data in accordance with the current HCAHPS *Quality Assurance Guidelines* and the quarterly data submission deadlines, both of which are posted at *http://www.hcahpsonline.org.* In order for a hospital to participate in the collection of HCAHPS data, a hospital must either: (1) Contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse; or (2) self-administer the survey without using a survey vendor provided that the hospital attends HCAHPS training and meets Minimum Survey Requirements as specified on the Web site at: *http://www.hcahpsonline.org.* A current list of approved HCAHPS survey vendors can be found on the HCAHPS Web site at: *http://www.hcahpsonline.org.*

We are proposing that the FY 2012 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from April 1, 2010 through December 31, 2010.

We are proposing that the FY 2013 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2011 through December 31, 2011.

We are proposing that the FY 2014 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2012 through December 31, 2012.

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

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

Any hospital that has five or fewer HCAHPS-eligible discharges in any month is no longer required to submit HCAHPS surveys for that month, although the hospital may voluntarily choose to submit these data. However, the hospital still must submit its total number of HCAHPS-eligible cases for that month to the QIO Clinical Warehouse as part of its quarterly HCAHPS data submission.

In order to ensure compliance with HCAHPS survey and administration protocols, hospitals and survey vendors must participate in all oversight activities. As part of the oversight process, during the onsite visits or conference calls, the HCAHPS Project Team will review the hospital's or survey vendor's survey systems and assess protocols based upon the most recent HCAHPS *Quality Assurance Guidelines.* All materials relevant to survey administration will be subject to review. The systems and program review includes, but is not limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) telephone

and IVR materials and facilities; (d) data receipt, entry and storage facilities; and (e) written documentation of survey processes. Organizations will be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. As needed, hospitals and survey vendors will be subject to follow-up site visits or conference calls. If CMS determines that a hospital is not compliant with HCAHPS program requirements, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements of the RHQDAPU program.

We continue to strongly recommend that each new hospital participate in an HCAHPS dry run, if feasible, prior to beginning to collect HCAHPS data on an ongoing basis to meet RHQDAPU program requirements. New hospitals can conduct a dry run in the last month of a calendar quarter. The dry run will give newly participating hospitals the opportunity to gain first-hand experience collecting and transmitting HCAHPS data without the public reporting of results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect HCAHPS dry-run data and submit the data to My QualityNet, the secure portion of QualityNet.

We are again encouraging hospitals to regularly check the HCAHPS Web site at *http://www.hcahpsonline.org* for program updates and information.

b. Additional Proposed RHQDAPU Program Procedural Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

(1) Chart-Abstracted Measures For Which Data Is Submitted Directly to CMS (via QualityNet)

Hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

Hospitals must continuously collect and report data to CMS (via QualityNet) for each of the quality measures under the topic areas that require chart abstraction (and are not registry-based topic areas). For the FY 2012 and FY 2013 payment determinations, the proposed topic areas are AMI, HF, PN, and SCIP. For the FY 2014 payment determination, the proposed topic areas are AMI, HF, PN, SCIP, Emergency Department Throughput (EDT), and Global Immunization (GIM).

For FY 2012, we are proposing that hospitals must submit data for five calendar year discharge quarters as follows: 4Q CY 2009, 1Q CY 2010 (AMI, HF and PN only), 2Q CY 2010, 3Q CY 2010 and 4Q CY 2010. For the FY 2013 payment determination, we are proposing that hospitals must submit data for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011. For the FY 2014 payment determination, hospitals must submit data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012. Hospitals must report these data by each quarterly deadline.

Hospitals must submit the data to the QIO Clinical Warehouse using the CMS Abstraction & Reporting Tool (CART), The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that meets the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through My QualityNet, the secure part of the QualityNet Web site. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.

Hospitals must submit complete data for each quality measure that requires chart abstraction in accordance with the joint CMS/The Joint Commission sampling requirements located on the QualityNet Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.

For the FY 2012 payment determination, we are proposing that hospitals must submit population and sampling data for three consecutive calendar year discharge quarters as follows: 2Q CY 2010, 3Q CY 2010 and 4Q CY 2010.

For the FY 2013 payment determination, we are proposing that hospitals must submit population and sampling data for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.

For the FY 2014 payment determination, we are proposing that hospitals must submit population and sampling data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012.

Hospitals must submit to CMS on a quarterly basis aggregate population and sample size counts for Medicare and non-Medicare discharges for the topic areas for which chart-abstracted data must be submitted (currently AMI, HF, PN, and SCIP). For clarification, we are proposing that hospitals are required to submit a numeric representation of their aggregate population and sample size count for each topic area even if the hospital has not treated patients in a specific topic area. For example, if a hospital has not treated AMI patients, the hospital is still required to submit a zero for its quarterly aggregate population and sample count for that topic in order to meet the requirement.

In order to reduce the burden on hospitals that treat a low number of patients in a RHQDAPU program topic area, a hospital that has five or fewer discharges (Medicare and non-Medicare combined) in a topic area during a quarter in which data must be submitted is not required to submit patient-level data for that topic area for the quarter. The hospital must still submit its aggregate population and sample size counts for Medicare and non-Medicare discharges for the topic areas each quarter. We also note that hospitals meeting the five or fewer patient discharge exception may voluntarily submit these data.

The quarterly data submission deadline for hospitals to submit patient level data for the proposed measures that require chart abstraction is 4½ months following the last discharge date in the calendar quarter. CMS will post the quarterly submission deadline schedule on the QualityNet Web site (*http://www.QualityNet.org*). Chart-abstracted measures have not been added for the FY 2012 payment determination. The collection of new chart-abstracted measures proposed for the FY 2013 payment determination would begin with the 1st calendar quarter 2011 discharges, for which the submission deadline would be August 15, 2011. The collection of new chart-abstracted measures proposed for the FY 2014 payment determination would begin with the 1st calendar quarter 2012 discharges, for which the submission deadline would be August 15, 2012. Hospitals must comply with the

discharge quarter submission deadlines in any fiscal year for each quarter for which data submission is required (Quarter 1—August 15th; Quarter 2—November 15th; Quarter 3—February 15th; Quarter 4—May 15th).

The data submission deadline for hospitals to submit aggregate population and sample size count data for the measures requiring chart abstraction is four months following the last discharge date in the calendar quarter. This requirement allows CMS to advise hospitals regarding their submission status in enough time for them to make appropriate revisions before the data submission deadline. We will post the aggregate population and sample size count data submission deadlines on the QualityNet Web site (*http://www.QualityNet.org*).

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

(2) Data Submission Requirements for HCAHPS

Hospitals must continuously collect and submit HCAHPS data in accordance with the current HCAHPS *Quality Assurance Guidelines,* which can be found on the HCAHPS Web site, *http://www.hcahpsonline.org.* The QIO Clinical Warehouse is able to accept submissions indicating zero HCAHPS-eligible discharges in a month. A hospital with zero HCAHPS-eligible discharges in a month must submit a zero as its total number of HCAHPS-eligible cases to the QIO Clinical Warehouse for that month as part of its quarterly HCAHPS data submission.

In order to reduce the burden on hospitals that treat a low number of patients that would be otherwise covered by the HCAHPS submission requirements, a hospital that has five or fewer HCAHPS-eligible discharges during a month is not required to submit HCAHPS surveys for that month. However, hospitals that meet this exception may voluntarily submit this data. A hospital with five or fewer HCAHPS-eligible discharges must submit its number of HCAHPS-eligible cases to the QIO Clinical Warehouse for the month(s) in which it had five or fewer HCAHPS-eligible discharges as part of its quarterly HCAHPS data submission.

(3) Procedures for Claims-Based Measures

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

• The following RHQDAPU program claims-based measures would be calculated using Medicare claims:

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Topic	FY 2012 Payment Determination: Proposed Claims-Based Quality Measures (No Additional Hospital Data Submission Required)
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI Acute Myocardial Infarction 30-day mortality –Medicare patients
	• MORT-30-HF Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN Pneumonia 30-day mortality -Medicare patients
Readmission Measures (Medicare Patients)	
	• READ-30-HF Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI Acute Myocardial Infarction (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI – 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ Patient Safety Indicator (PSI) and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Hospital Acquired Condition Measures	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	• Vascular Catheter-Associated Infection*
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control*

*New proposed measure

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For the claims-based RHQDAPU program measures listed above, hospitals are not required to submit the data to the QIO Clinical Warehouse. CMS uses the existing Medicare fee-for-service claims to calculate the measures. For the FY 2012 payment determination, CMS would use up to 3 years of discharges prior to January 1, 2011 (as appropriate for the measure), to calculate the 30-day mortality and 30-day readmission measures AHRQ PSI, IQI and Composite measures (including the AHRQ PSI and Nursing Sensitive Care measure, Death among surgical inpatients with serious, treatable complications), and the proposed new HAC Measures. For the FY 2013 and FY 2014 payment determinations, CMS would use up to 3 years of discharges (as appropriate for the measure) prior to January 1, 2012, and January 1, 2013 respectively. Hospitals are required to appropriately report the POA indicator in conjunction with ICD–9–CM coding to determine the presence of HACs so that the proposed HAC measures can be calculated for the RHQDAPU program using Medicare claims.

(4) Data Submission Requirements for Structural Measures

• We are proposing that for the FY 2012 payment determination, hospitals submit the required registry participation information once for the structural measures via a Web-based collection tool between July 1, 2011–August 15, 2011 with respect to the time period of July 1, 2010 through December 31, 2010.

Below is the list of structural measures we are proposing to adopt for the FY 2012 payment determination:

Topic	FY 2012 payment determination: Proposed structural measures
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.
Stroke Care	• Participation in a Systematic Clinical Database Registry for Stroke Care.
Nursing Sensitive Care	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

(5) Data Submission of All-Patient Volume Data for Selected MS–DRGs Related to RHQDAPU Program Measures

For submission of the all-patient volume data for selected MS–DRGs, we are proposing that hospitals submit patient level information needed for CMS to apply the MS–DRG grouper software to calculate the all-patient MS–DRG volumes, the data elements for which would be defined in the Specifications Manual. Hospitals would begin submitting this data quarterly via QualityNet beginning with January 1, 2011 discharges.

We invite comment on an alternative that hospitals submit hospital-level all-patient volume data based upon specific ICD–9–CM codes that are related to the selected MS–DRGs (rather than the patient-level data) necessary for CMS to calculate the MS–DRGs. Hospitals would begin submitting this data quarterly via QualityNet beginning with January 1, 2011 discharges.

(6) Proposed Data Submission and Reporting Requirements for HAI Measures Reported via NHSN

We are proposing that hospitals participating in RHQDAPU submit the data elements needed to calculate the Central Line Associated Blood Stream Infection and Surgical Site Infection measures to the NHSN using the standard procedures that have been set forth by CDC for NHSN participation in general and for submission of these two measures to NHSN in particular. This would include NHSN participation forms and indications to CDC allowing CMS to access data for these two measures for RHQDAPU program purposes, adherence to training requirements, use of standard CDC measure specifications, data element definitions, data collection requirements and instructions, and data reporting timeframes. Detailed requirements for NHSN participation, measure specifications, and data collection can be found at *http://www.cdc.gov/nhsn/*. Hospitals must use the current specifications and data collection tools available on the CDC Web site to submit data for the Central Line Associated Bloodstream Infection and Surgical Site Infection measures. We are proposing that hospitals would submit data for these two measures to CDC's NHSN on a monthly basis for discharges occurring on or after January 1, 2011.

For the FY 2013 payment determination, we are proposing that hospitals must submit HAI data via the NHSN for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.

For the FY 2014 payment determination, hospitals must submit HAI data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012.

We are proposing that once quarterly each hospital would utilize an automated report function that will be made available to submitters in the NHSN, to generate a quarterly report containing hospital-level numerator, denominator, and exclusion counts for these two CDC measures specifically for the RHQDAPU program. The CDC will create this automated RHQDAPU report function and add it to NHSN's reporting functionalities in the next few months. While hospitals may be reporting other data elements to CDC for other reporting programs (that is: State mandated surveillance programs), the quarterly RHQDAPU report that would be generated within NHSN would only contain those data elements needed to calculate the two measures currently being proposed for the RHQDAPU program. CMS will access the reports in the NHSN and will compile the reports for RHQDAPU program and public reporting purposes.

We invite comment on the proposed mechanism for submitting data for the Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure for the RHQDAPU program beginning with the FY 2012 payment determination.

(7) Data Submission Requirements for Registry-Based Measures

We are proposing that hospitals participating in RHQDAPU would be required to choose at least one of four registry based measure topics (ICD Complications, Stroke, Nursing Sensitive Care, or Cardiac Surgery), and would submit the data needed to calculate the measures included in the chosen registry-based topic to a qualified registry in order to meet the requirements to receive the full FY 2013 annual payment update.

We are proposing that hospitals then would arrange to have the qualified registry calculate the measures and submit to the QIO Clinical Warehouse the results, as well as the numerator, denominator, and exclusions. Any arrangement reached between the hospital and the qualified registry must comply with HIPAA. The qualified registry would also submit registry-derived hospital-level measure calculations to the QIO Clinical Warehouse using a CMS-specified record layout and file format that we will make available.

Our program and its data system must maintain compliance with HIPAA requirements for requesting, processing, storing, and transmitting data. For the FY 2013 RHQDAPU payment determination, hospitals would need to submit data for the proposed registry-based measures to the qualified registry in the form and manner and by the deadline(s) specified by the registry.

CMS will begin qualifying registries for the four proposed registry-based topics so that hospitals may begin submitting data for discharges beginning January 1, 2011. Proposed registry qualification criteria are discussed in a section V.A.13. of this proposed rule. We are proposing to post on the RHQDAPU program section of the QualityNet Web site *http://www.qualitynet.org* a list of qualified registries for the FY 2013 RHQDAPU payment determination, including the registry name, contact information, and the measure(s) that the registry has been

qualified to collect and report for the RHQDAPU program.

We anticipate posting the list of qualified FY 2011 registries as soon as we have completed vetting the registries interested in participating in the FY 2013 RHQDAPU program payment determination and identified the qualified registries for the FY 2013 RHQDAPU program payment determination, which we anticipate will be completed by December 31, 2010. Specific data submission requirements for the registry-based measures are discussed below:

(A) Hospitals That Choose To Report the ICD Complications Measure

If the hospital chooses the ICD Complications measure, it would submit specified data elements for specified populations to the qualified ICD registry. We intend to establish criteria and begin qualifying registries for this topic so that hospitals can begin submitting data for discharges beginning January 1, 2011. The hospital would follow the standard participation and reporting procedures set by the registry regarding the submission of data elements for the particular measures we have specified for the topic. These data elements and population definitions will be listed in the Specifications Manual.

Hospitals must allow the qualified registry it is using to report the patient-level data to CMS in order to calculate the ICD complications measure.

(B) Hospitals That Choose To Report Either the Stroke, Nursing Sensitive Care, or Cardiac Surgery Measures

If a hospital chooses the Stroke, Nursing Sensitive Care, or Cardiac Surgery measure topics, it would submit data on the measures listed for these topics to a qualified registry for the topic. CMS intends to establish criteria and begin qualifying registries for these topics so that hospitals can begin submitting data for discharges beginning January 1, 2011. The hospital would follow the standard participation and reporting procedures set by the registry regarding the submission of data elements for the particular measures CMS has specified for the topic. Additionally, the hospital would agree to allow the registry to send calculations of the measures, numerator, denominator and exclusion counts to CMS for the RHQDAPU program.

6. RHQDAPU Program Disaster Extensions and Waivers

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24176), we solicited public comment about rules we could adopt that would enable hospitals to request either an extension or a waiver of various RHQDAPU program requirements in the event of a disaster (such as a hurricane that damages or destroys the hospital).

Specifically, we welcomed public comment on the following issues:

- Recommendations for rules that we could follow when considering whether to grant an extension or waiver of RHQDAPU program requirements in the event of a disaster, including suggested criteria that we should take into account (for example, specific hospital infrastructure damage, hospital closure time period, degree of destruction of medical records, impact on data vendors, and long-term evacuation of discharged patients impacting HCAHPS survey participation).
- The role that QIOs and QIO support contractors should play in the event of a disaster, including communicating with affected hospitals, communicating with State hospital associations, and collecting information directly from hospitals.
- How CMS extension or waiver decisions should be communicated to affected hospitals.
- Any other issues commenters deem relevant to a hospital's request for an extension or waiver of RHQDAPU program requirements in the event of a disaster.

We responded to public comments in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43881). We recognize that there are times when hospitals are unable to submit quality data due to extraordinary circumstances that are not within their control. It is our goal to not penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times.

Therefore, we are proposing a process for hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the hospital. Under the proposed process, in the event of extraordinary circumstances not within the control of the hospital, for the hospital to receive consideration for an extension or waiver of the requirement to submit quality data for one or more quarters, a hospital must submit to the QIO in the hospital's State a request form that will be made available on the QualityNet Web site. The following information should be noted on the form:

- Hospital CCN;
- Hospital Name;
- CEO and any other designated personnel contact information, including name, e-mail address, telephone number, and mailing address (must include a physical address, a post office box address is not acceptable);
- Hospital's reason for requesting an extension or waiver;
- Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the hospital will again be able to submit RHQDAPU data, and a justification for the proposed date.

The request form must be signed by the hospital's CEO. A request form must be submitted within 45 days of the date that the extraordinary circumstance occurred. The QIO in the hospital's state will forward the request form to CMS. Following receipt of the request form, CMS will: (1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated hospital personnel, notifying them that the hospital's request has been received; and (2) provide a formal response to the CEO and any additional designated hospital personnel using the contact information provided in the request notifying them of our decision.

This proposal does not preclude CMS from granting waivers or extensions to hospitals that have not requested them when we determine that an extraordinary circumstance, such as an act of nature (for example, hurricane), affects an entire region or locale. If CMS makes the determination to grant a waiver or extension to hospitals in a region or locale, CMS will communicate this decision through routine communication channels to hospitals, vendors and QIOs, including but not limited to issuing memos, e-mails and notices on the QualityNet Web site. We invite comment on this proposal.

7. Proposed Chart Validation Requirements for Chart-Abstracted Measures

a. Chart Validation Requirements and Methods for the FY 2012 Payment Determination

For the FY 2012 payment determination, we will use the chart validation requirements and methods that we adopted for FY 2012 in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43884 through 43889). These requirements, as well as additional information on these requirements, will be posted on the QualityNet Web site after we issue the FY 2011 IPPS/RY 2011 LTCH PPS final rule.

Specifically, we will:

- Randomly select on an annual basis 800 participating hospitals that

submitted chart-abstracted data for at least 100 discharges combined in the measure topics to be validated. To determine whether a hospital meets this "100-case threshold," we will look to the discharge data submitted by the hospital during the calendar year three years prior to the fiscal year of the relevant payment determination. For example, if the 100-case threshold applied for the FY 2011 payment determination (which it will not), the applicable measure topics would be AMI, HF, PN, and SCIP, and we would choose 800 hospitals that submitted discharge data for at least 100 cases combined in these topics during calendar year 2008. If a hospital did not submit discharge data for at least 100 cases in these topics during CY 2008, we would not select the hospital for validation. We will announce the topic areas that apply for the FY 2012 payment determination at a later date, and we plan to select the first 800 hospitals in July 2010. We will select hospitals for the FY 2012 validation if they meet the 100-case threshold during CY 2009. We adopted this 100-case threshold because we believe that it strikes the appropriate balance between ensuring that the selected hospitals have a large enough patient population to be able to submit sufficient data to allow us to complete an accurate validation, while not requiring validation for hospitals with a low number of submitted quarterly cases and relatively unreliable measure estimates. Based on previously submitted data, we estimate that 98 percent of participating RHQDAPU program hospitals will meet this threshold and, thus, be eligible for validation. As noted below, we solicited comments and suggestions on how we might be able to target the remaining 2 percent of hospitals for validation.

- Validate for each of the 800 hospitals a randomly selected stratified sample for each quarter of the validation period. Each quarterly sample will include 12 cases, with at least one but no more than three cases per topic for which chart-abstracted data was submitted by the hospital. However, we recognize that some selected hospitals might not have enough cases in all of the applicable topics to submit data (for example, if they have 5 or fewer discharges in a topic area in a quarter). For those hospitals, we will validate measures in only those topic areas for which they have submitted data. For the FY 2012 payment determination, we will validate 1st calendar quarter 2010 through 3rd calendar quarter 2010 discharge data. We will validate 3 quarters of data for FY 2012 in order to provide hospitals with enough time to assess their medical record documentation and abstraction practices, and to take necessary corrective actions to improve these practices, before documenting their 1st calendar quarter 2010 discharges into medical records that may be sampled as part of this proposed validation process.

The CDAC contractor will, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit 12 randomly selected medical charts from which data was abstracted and submitted by the hospital to the QIO Clinical Warehouse. We note that, under our current requirements, hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

In addition, we will continue the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC contractor requests for second calendar quarter 2009 paper medical records, the CDAC contractor will request paper copies of the randomly selected medical charts from each hospital via certified mail (or other trackable method that requires a hospital representative to sign for the letter), and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC contractor. If the hospital does not comply within 30 days, the CDAC contractor will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC contractor medical record request. If the hospital still does not comply, then the CDAC contractor will assign a "zero" score to each measure in each missing record. The letter from the CDAC contractor is addressed to the hospital's medical record staff identified by the hospital to their state Quality Improvement Organization (QIO). CMS recommends that hospitals routinely check with their State QIO to ensure the correct person is listed to receive the record request. If CMS has evidence from the CDAC contractor that the hospital received both letters requesting medical records (as determined by the tracking system used by the CDAC contractor), the hospital is responsible for not returning their charts and will not be able to submit charts as part of their reconsideration request.

Under the validation methodology, once the CDAC contractor receives the charts, it will re-abstract the same data submitted by the hospitals and calculate the percentage of matching RHQDAPU program measure numerators and denominators for each measure within each chart submitted by the hospital. Specifically, we will estimate the accuracy by calculating a match rate percent agreement for all of the variables submitted in all of the charts. For any selected record, a measure's numerator and denominator can have two possible states, included or excluded, depending on whether the hospital accurately included the cases in the measure numerator(s) and denominator(s). We will count each measure in a selected record as a match if the hospital-submitted measure numerator and denominator sets match the measure numerator and denominator states independently abstracted by our contractor. For example, one heart failure case from which data has been abstracted for four RHQDAPU program chart-abstracted measures (that is, HF–1, HF–2, HF–3, and HF–4) would receive a 75-percent match if three out of four of the hospital-reported heart failure measure numerator and denominator states matched the re-abstracted numerator and denominator states. This proposed scoring approach is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress, and is illustrated in further detail using an example in pages 83–84 of the report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate, and it was supported by many commenters when we requested comment in the FY 2009 and FY 2010 IPPS final rules for input about the RHQDAPU program validation process (73 FR 48622 and 48623, 74 FR 43886 and 43887).

Under the validation methodology, we will:

- Use, as we currently do, each selected case as a cluster comprising one or multiple measures utilized in a validation score estimate. Each selected case will have multiple measures included in the validation score (for example, for the FY 2011 payment

determination, a heart failure record will include 4 heart failure measures). Specifically, we will continue using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter and clinical topic is treated as a stratum for variance estimation purposes.

We believe that the clustering approach is a statistically appropriate technique for calculating the annual validation confidence interval. Because we will not be validating all hospital records, we need to calculate a confidence interval that incorporates a potential sampling error. Our clustering approach incorporates the degree of correlation at the individual data record level, because our previous validation experience indicates that hospital data mismatch errors tend to be clustered in individual data records. We have used this clustering since the inception of the RHQDAPU program validation requirement to calculate variability estimates needed for calculating confidence intervals (70 FR 47423).

- Use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score; and
- Require all RHQDAPU program participating hospitals selected for validation to attain at least a 75 percent validation score per quarter to pass the validation requirement.

We believe that this modified validation methodology incorporates many of the principles supported by the vast majority of commenters in response to our solicitation for public comments in the FY 2009 and FY 2010 IPPS proposed rule (73 FR 23658 through 23659, 74 FR 43886 and 43887). Specifically, we believe that the increased annual sample size per hospital will provide more reliable estimates of validation accuracy. The sample size of 12 records per quarter would provide a total of 36 records across the three sampled quarters for the FY 2012 payment determination, and 48 records in subsequent years. This estimate would improve the reliability of our validation estimate, as compared to the current RHQDAPU program annual validation sample of 20 cases per year. We also believe that modifying the validation score to reflect measure numerator and denominator accuracy will ensure that accurate data are posted on the *Hospital Compare* Web site.

In addition, we believe that stratified quarterly samples by topic will improve the feedback provided to hospitals. CMS will provide validation feedback to hospitals about all sampled topics submitted by the hospitals each quarter. Because all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match, we reduced the passing threshold from 80 percent to 75 percent. We will use a one-tail confidence interval to calculate the validation score because we strongly believe that a one-tail test most appropriately reflects the pass or fail dichotomous nature of the statistical test regarding whether the confidence interval includes or is completely above the 75 percent passing validation score.

We also will continue to allow hospitals that fail to meet the passing threshold for the quarterly validation an opportunity to appeal the validation results to their State QIO. QIOs are currently tasked by CMS to provide education and technical assistance about RHQDAPU program data abstraction and measures to hospitals, and the quarterly validation appeals process will provide hospitals with an opportunity to both appeal their quarterly results and receive education free of charge from their State QIO. This State QIO quarterly validation appeals process is independent of the proposed RHQDAPU program reconsideration procedures for hospital reconsideration requests involving validation for the FY 2010 payment update proposed in this proposed rule.

b. Proposed Supplements to the Chart Validation Process for the FY 2013 Payment Determination and Subsequent Years

For FY 2013 and future years, we are also proposing to adopt the same validation requirements that we adopted for the FY 2012 payment determination, except as set forth below.

For FY 2013 and future years, we are proposing to modify our FY 2012 criteria by adding a targeting criterion, refining our random sample approach, and changing our data discharge quarters validated as part of our proposed synchronization of RHQDAPU timelines. Specifically, we are proposing the following changes for FY 2013:

We are proposing to validate the data submitted by a hospital if the hospital failed the previous year's RHQDAPU program validation. We are proposing this targeting criterion to improve data accuracy for all hospitals failing our validation requirement in a previous year. We believe that this proposal is an appropriate method to ensure data accuracy, since it targets our resources on the hospitals with the least accurate data based on FY 2012 validation results. We also believe that these hospitals must correct the data inaccuracies identified in RHQDAPU validation for their internal quality improvement and RHQDAPU measures publicly reported on *Hospital Compare.* Our proposal allows CMS to assess the accuracy of these hospitals' data and provide feedback to hospitals until they comply with our RHQDAPU validation requirement.

Specifically, we are proposing that all hospitals selected for validation for the FY 2012 payment determination and that fail the validation will be selected for validation for the FY 2013 payment determination. Based on data analysis of past validation results, we estimate that targeting these hospitals would add about 20 to 40 hospitals to our list of validated hospitals to be selected in the FY 2013 validation sample.

For FY 2013, we also are proposing the following changes to the FY 2012 RHQDAPU validation random sample approach:

Starting in FY 2013, we are proposing to discontinue the 100 case minimum threshold for selection in the RHQDAPU 800 hospital random sample. We believe that discontinuing this requirement would improve the robustness of the RHQDAPU program validation sample by including the smallest hospitals participating in the RHQDAPU program in the sample. All hospitals successfully submitting at least one RHQDAPU case for the third calendar quarter of the year two years prior to the year to which the validation applies would be eligible to be selected for validation. For example, for the FY 2013 payment determination, we would select the sample in early 2011, and all hospitals that submitted at least one RHQDAPU case for third quarter 2010 discharges would be eligible to be selected. Starting in FY 2013, we are proposing this change to the RHQDAPU random validation sample, rather than including these hospitals in a targeted sample, to ensure that all RHQDAPU participating hospitals are equally likely to be selected in the random validation sample.

For the FY 2013 payment determination, we are proposing to modify the quarterly stratified sample selection by reallocating sample cases when a hospital has submitted fewer than three cases in a topic within a quarter. In these rare cases, we are proposing to randomly reallocate the extra sample cases to other topics with more than 3 submitted quarterly cases.

This proposed modification is designed to ensure that CMS selects 12 cases for all hospitals in a quarter, including those hospitals specializing in only one topic. For example, an orthopedic specialty surgery hospital submitting only SCIP measure cases in a given quarter would have only SCIP measure cases randomly selected in the validation sample for that quarter. This would provide a more reliable estimate of abstraction and measure accuracy by maintaining the same 12 case total quarterly validation sample.

For the FY 2013 payment determination, we also are proposing to validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011 in accordance with our proposed synchronization of RHQDAPU data as outlined in section V.A.5.a.(2) of this proposed rule. This lag between the time a hospital submits data and the time we can validate that data is necessary because data is not due to the QIO Clinical Warehouse until 4½ months after the end of each quarter, and we need additional time to select hospitals and complete the validation process.

We are also considering additional changes to our validation approach for future years. Beginning with the FY 2014 payment determination, we are considering adding two strata to the current RHQDAPU program validation sample of SCIP, AMI, HF, and PN cases. We are considering selecting 2 additional validation samples of 3 cases per selected hospital per quarter. One additional quarterly sample would enable us to validate the Central Line Associated Bloodstream Infection (CLABSI) and Surgical Site Infection (SSI) measures that we are proposing to add to the RHQDAPU measure set for the FY 2013 payment determination, and the second additional quarterly sample would enable us to validate the ED-Throughput and the Immunization for Influenza and Immunization for Pneumonia global measures that we are proposing to add to the RHQDAPU measure set for the FY 2014 payment determination. Thus, we would be validating a total of 18 records per quarter per validated hospital in six strata (1) SCIP, (2) AMI, (3) HF, (4) PN, (5) CLABSI/SSI, and (6) ED–Throughput/Immunization measures. We are also considering requiring hospitals to sign a written form explicitly granting CMS access to their patient level data submitted for the proposed Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure. We believe that the CLABSI/SSI stratum is necessary to validate the data in the reports that we will access from NHSN for the RHQDAPU program. We invite comment on our validation proposals and considerations.

We note that we are considering proposing, beginning with the FY 2015 payment determination, to add hospitals to our validation sample if they were open under their current CCNs in FY 2012 but not selected for validation in the three previous annual RHQDAPU validation samples. We are considering this addition to supplement our validation approach to ensure that all eligible RHQDAPU program hospitals are selected for validation at least once every 4 years. We are considering this addition beginning with the FY 2015 payment determination because FY 2015 would be the fourth year that we will be using the random validation approach.

8. Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years

For the FY 2011 payment determination and subsequent years, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24180), we proposed to require hospitals to electronically acknowledge on an annual basis the completeness and accuracy of the data submitted for the RHQDAPU program payment determination. Hospitals will be able to submit this acknowledgement on the same Web page that they use to submit data necessary to calculate the structural measures, and we believe that this Web page will provide a secure vehicle for hospitals to directly acknowledge that their information is complete and accurate to the best of their knowledge. A single annual electronic acknowledgement will provide us with explicit documentation acknowledging that the hospital's data is accurate and complete, but will not unduly burden hospitals. We noted that commenters generally supported the idea of electronic attestation in the FY 2009 IPPS final rule (73 FR 48625) at the point of data submission to the QIO Clinical Warehouse.

In addition, the Government Accountability Office (GAO) recommended in a 2006 report (GAO–06–54) that hospitals self-report that their data are complete and accurate. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43890) for the FY 2010 payment determination, we required hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2009, and August 15, 2009. Hospitals will acknowledge that all information that is, or will be, submitted as required by the RHQDAPU program for the FY 2010 payment determination is complete and accurate to the best of their knowledge.

We are proposing to require hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2010 and August 15, 2010 for data to be used for the FY 2012 RHQDAPU program payment determination.

9. Proposed Public Display Requirements for the FY 2012 Payment Determination and Subsequent Years

Section 1886(b)(3)(B)(viii)(VII) of the Act provides that the Secretary shall establish procedures for making data submitted under the RHQDAPU program available to the public. As we noted in section V.A.1.c.(3) of this proposed rule, the RHQDAPU program quality measures are typically reported on the *Hospital Compare* Web site (*http://www.hospitalcompare.hhs.gov*), but on occasion are reported on other CMS Web sites. We require that hospitals sign a Notice of Participation form when they first register to participate in the RHQDAPU program. Once a hospital has submitted a form, the hospital is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS (72 FR 47360). Hospitals signing this form agree that they will allow CMS to publicly report the quality measures included in the RHQDAPU program.

We will continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

10. Proposed Reconsideration and Appeal Procedures for the FY 2011 Payment Determination

The general deadline for submitting a request for reconsideration in connection with the FY 2011 payment determination is November 1, 2010. As discussed more fully below, we are proposing that all hospitals submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).

For the FY 2011 payment determination, we are proposing to continue utilizing most of the same procedures that we utilized for the FY 2010 requests for reconsideration. Under these proposed procedures, the hospital must—

Submit to CMS, via QualityNet, a Reconsideration Request form (available on the *QualityNet* Web site) containing the following information:

—Hospital CMS Certification number (CCN).
—Hospital Name.
—CMS-identified reason for failure (as provided in the CMS notification of failure letter to the hospital).
—Hospital basis for requesting reconsideration. This must identify the hospital's specific reason(s) for believing it met the RHQDAPU program requirements and should receive the full FY 2011 IPPS annual payment update.
—CEO contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box). We no longer require that the hospital's CEO sign the RHQDAPU program reconsideration request. We have found that this requirement increases the burden for hospitals because it prevents them from electronically submitting the RHQDAPU program reconsideration request forms. In addition, to the extent that a hospital can submit a request for reconsideration on-line, the burden on our staff is reduced and, as a result, we can more quickly review the request.
—QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box).
—Paper medical record requirement for reconsideration requests involving validation. We are proposing that if a hospital asks us to reconsider an adverse RHQDAPU program payment decision made because the hospital failed the validation requirement, the hospital must submit paper copies of all the medical records that it submitted to the CDAC contractor each quarter for purposes of the validation. Hospitals must submit this documentation to a CMS contractor. The contractor will be a QIO support contractor, which has authority to review patient level information under 42 CFR part 480. We will post the address where hospitals can ship the paper charts on the QualityNet Web site after we issue the FY 2011 IPPS/LTCH PPS final rule. Hospitals submitting a RHQDAPU program validation reconsideration request will have all mismatched data reviewed by CMS, and not their State QIO. (As discussed in section V.A.6.b. of this proposed rule, the State QIO is available to conduct a quarterly validation appeal if so requested by a hospital.)

For the FY 2011 payment determination, the RHQDAPU program data that will be validated is 4th calendar quarter 2008 through 3rd quarter calendar year 2009 discharge data. Hospitals must provide a written justification for each appealed data element classified during the validation process as a mismatch. We will review the data elements that were labeled as mismatched, as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request. As we mentioned above, we are proposing that all hospitals submit a reconsideration request to CMS and receive a decision on that request prior to submitting a PRRB appeal. We believe that the reconsideration process is less costly for both CMS and hospitals, and that this requirement will decrease the number of PRRB appeals by resolving issues earlier in the appeals process.

Following receipt of a request for reconsideration, we will—

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

• Provide written notification to the hospital CEO, using the contact information provided in the reconsideration request, regarding our decision. We expect the process to take approximately 90 days from the reconsideration request due date of November 1, 2010.

As we stated in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43892), the scope of our review when a hospital requests reconsideration because it failed our validation requirements will be as follows:

1. *Hospital requests reconsideration for CDAC contractor-abstracted data elements classified as mismatches affecting validation scores.* Hospitals must timely submit a copy of the entire requested medical record to the CDAC contractor during the quarterly validation process for the requested case to be eligible to be reconsidered on the basis of mismatched data elements.

2. *Hospital requests reconsideration for medical record copies submitted during the quarterly validation process and classified as invalid record selections.* Invalid record selections are defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the CDAC contractor (in other words, the contractor determines that the hospital returned a medical record that is different from that which was requested). If the CDAC contractor determines that the hospital has submitted an invalid record selection case, it awards a zero validation score for the case because the hospital did not submit the entire copy of the medical record for that requested case. During the reconsideration process, our review of invalid record selections will initially be limited to determining whether the record submitted to the CDAC contractor was actually an entire copy of the requested medical record. If we determine during reconsideration that the hospital did submit the entire copy of the requested medical record, then we would abstract data elements from the medical record submitted by the hospital.

3. *Hospital requests reconsideration for medical records not submitted to the CDAC contractor within the 45 calendar day deadline.* Our review will initially be limited to determining whether the CDAC contractor received the requested record within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice. If we determine during reconsideration that the CDAC contractor did receive a paper copy of the requested medical record within 45 calendar days, then we would abstract data elements from the medical record submitted by the hospital. If we determine that the hospital received two letters requesting medical records and still did not submit the requested records within the 45 day period, CMS will not accept these records as part of the reconsideration. CMS will not abstract data from charts not received timely by the CDAC contractor.

In sum, we are initially limiting the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we will not abstract medical records that were not submitted to the CDAC contractor during the quarterly validation process. We will expand the scope of our review only if we find during the initial review that the hospital correctly and timely submitted the requested medical records. In that case, then we would abstract data elements from the medical record submitted by the hospital as part of our review of its reconsideration request.

If a hospital is dissatisfied with the result of a RHQDAPU program reconsideration decision, the hospital may file a claim under 42 CFR part 405,

Subpart R (a PRRB appeal). We are again soliciting public comments on the extent to which these proposed procedures will be less costly for hospitals, and whether they will lead to fewer PRRB appeals.

11. Proposed RHQDAPU Program Withdrawal Deadlines

We are proposing to accept RHQDAPU program withdrawal forms for the FY 2012 payment determination from hospitals until August 15, 2011. We are proposing this deadline so that we would have sufficient time to update the FY 2012 payment to hospitals starting on October 1, 2011. If a hospital withdraws from the program for the FY 2012 payment determination, it will receive a 2.0 percentage point reduction in its FY 2012 annual payment update. We noted that once a hospital has submitted a Notice of Participation form, it is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.

12. Electronic Health Records (EHRs)

a. Background

Starting with the FY 2006 IPPS final rule, we have encouraged hospitals to take steps toward the adoption of EHRs (also referred to in previous rulemaking documents as electronic medical records) that will allow for reporting of clinical quality data from the EHRs directly to a CMS data repository (70 FR 47420 through 47421). We encouraged hospitals that are implementing, upgrading, or developing EHR systems to ensure that the technology obtained, upgraded, or developed conforms to standards adopted by HHS. We suggested that hospitals also take due care and diligence to ensure that the EHR systems accurately capture quality data and that, ideally, such systems provide point-of-care decision support that promotes optimal levels of clinical performance.

We also continue to work with standard setting organizations and other entities to explore processes through which EHRs could speed the collection of data and minimize the resources necessary for quality reporting as we have done in the past.

We note that we have initiated work directed toward enabling EHR submission of quality measures through EHR standards development and adoption. We have sponsored the creation of electronic specifications for quality measures that are currently proposed for the RHQDAPU program and measures under future consideration. We look to continue this activity in the future.

b. EHR Testing of Quality Measures Submission

As we have previously stated, we are interested in the reporting of quality measures using EHRs, and we continue to encourage hospitals to adopt and use EHRs that conform to the certification criteria as will be defined by the Office of the National Coordinator for Health Information Technology, HHS at 45 CFR part 170. We believe that the testing of EHR submission is an important and necessary step to establish the ability of EHRs to report clinical quality measures and the capacity of CMS to receive such data.

The electronic specifications and interoperability standards for EHR-based collection and transmission of the data elements for the ED Throughput, Stroke, and Venous Thromboembolism (VTE) measures have been finalized by the Health Information Technology Standards Panel (HITSP) and are available for review and testing at *http//www.HITSP.org*. We anticipate testing the components required for the submission of clinical quality data extracted from EHRs for these measures, and are exploring different mechanisms and formats that will aid the submission process, as well as ensure that the summary measure results extracted from the EHRs are reliable.

We anticipate moving forward with testing CMS' technical ability to accept data from EHRs for the ED, Stroke, and VTE measures as early as summer of 2011. We anticipate building upon the work completed by the HITSP in both the Connectathon and Health Information Management Systems Society (HIMSS) Interoperability Showcase. This testing will encompass an "end to end" view of data transmission. Pursuant to the Paperwork Reduction Act, we have previously published a **Federal Register** notice and information collection request for CMS–10296 (74 FR 44366) seeking public comments on the process we intended to follow to select EHR vendors/hospitals for testing CMS ability to accept EHR-based data submissions. We will notify interested parties of changes in the process and timeline for testing via the Inpatient EHR testing Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/15_HospitalInpatientEHRTesting.asp.*

The test measures described above are not currently required under the RHQDAPU program. In addition, the posting of the electronic specifications for any particular measure should not be interpreted as a signal that we intend to select the measure for inclusion in the RHQDAPU program measure set.

c. HITECH Act EHR Provisions

The HITECH Act (Title IV of Division B of the ARRA, together with Title XIII of Division A of the ARRA) authorizes payment incentives under Medicare for the adoption and use of certified EHR technology beginning in FY 2011. Hospitals are eligible for these payment incentives if they meet requirements for meaningful use of certified EHR technology, which include reporting on quality measures using certified EHR technology. With respect to the selection of quality measures for this purpose, under section 1886(n)(3)(A)(ii) of the Act, as added by section 4102 of the HITECH Act, the Secretary shall select measures, including clinical quality measures, that hospitals must provide to CMS in order to be eligible for the EHR incentive payments. With respect to the clinical quality measures, section 1886(n)(3)(B)(i) of the Act requires the Secretary to give preference to those clinical quality measures that have been selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act or that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act. Any measures must be proposed for public comment prior to their selection, except in the case of measures previously selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act.

Thus, the RHQDAPU program and the HITECH Act have important areas of overlap and synergy with respect to the reporting of quality measures using EHRs. We believe the financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the RHQDAPU program. Further, these efforts to test the submission of quality data through EHRs may provide a foundation for establishing the capacity of hospitals to send, and for CMS to receive, quality measures via hospital EHRs for future RHQDAPU program measures.

We again note that the provisions in this proposed rule do not implicate or implement any HITECH statutory provisions. Those provisions are the subject of separate rulemaking and public comment.

13. Qualification of Registries for RHQDAPU Data Submission

In section V.A.3.c.(3) of this proposed rule, we proposed that hospitals would select at least one of four registry-based measure topics for which they will report data on proposed measures to a qualified registry beginning with January 1, 2011 discharges, and allow the registry to calculate and report measure data for the specified measures to CMS (via QualityNet) for RHQDAPU program purposes. The process and requirements that we are proposing to use to determine whether a registry is qualified to collect and submit quality measure data are described below. We will post on the RHQDAPU program section of the QualityNet Web site *http://www.qualitynet.org* no later than December 31, 2010 a list of qualified registries for the FY 2013 RHQDAPU payment determination, including the registry name, contact information, and the measure(s) for which the registry is qualified and will report for the FY 2013 RHQDAPU payment determination. We have proposed measures for inclusion in each of the four registry-based topics, and a registry seeking to be qualified for a particular topic would have to agree to collect and report the measures included in the topic. The proposed measures support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries (such as, prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; and effective management of acute and chronic episodes of care). We note, however, that none of the registries that we qualify for this purpose will be acting as a CMS contractor or agent. In other words, hospitals will still be responsible for making sure that the data it submits to the qualified registry is successfully processed and transmitted by the registry to CMS.

We are proposing to implement a self-nomination process for registries seeking to submit FY 2013 RHQDAPU program quality measures (including measure calculations, numerators, denominators, and exclusions) on behalf of hospitals beginning with January 1, 2011 discharges. A registry would be able to self-nominate if it meets the following requirements:

- The registry has been collecting data elements needed to calculate the particular measures that are being proposed for inclusion in the registry-based topic for which the registry is seeking qualification for at least 3 years prior to January 1, 2010.
- As of January 1, 2010, the registry has been collecting such data from at least 750 hospitals.
- The registry must have the capability to collect from hospitals all of the data elements which are included in the measure specifications and calculate the results for the specified measures. The measures are NQF-endorsed and will be listed in the Specifications Manual.
- The registry must agree to report the hospital level measure data to CMS (via QualityNet). During the registry qualification process, CMS will inform the registries of the specified reporting format which will include:
  - The volume of eligible cases (reporting denominator);
  - The volume of numerator events for the quality measure (reporting numerator);
  - The number of cases excluded from the measure;
  - The measure results
- The registry must agree to transmit quality measure data in a CMS-approved format. We expect that this CMS-specified record layout will be made available in late 2010;
- The registry must be able to perform data quality validation checks on the data received from hospitals to determine if the data submitted by the hospitals are accurate and agree to submit an acceptable "validation strategy" to CMS by December 15, 2011. A validation strategy ascertains whether hospitals have submitted data accurately to the registry. An acceptable validation strategy may include such provisions as the registry being able to verify the accuracy of hospital data through random sampling or through the hospital's adherence to a required sampling method;
- The registry must agree to enter into and maintain with its participating hospitals an appropriate Business Associate agreement that complies with HIPAA.
- The registry must obtain and keep on file signed documentation showing that each of its participating hospitals has authorized the registry to calculate and submit the quality measure hospital-level data specified by CMS to CMS. This documentation must be obtained at the time the hospital arranges to submit RHQDAPU program quality measure data to the registry;
- The registry must agree to provide CMS with access (if requested) to review the data that the hospital submitted to it for purposes of the RHQDAPU program;
- The registry must agree to indicate to CMS upon request whether a particular hospital has satisfied the registry's participation requirements;
- The registry must agree to provide CMS with a signed, written attestation statement via mail or e-mail which states that the quality measure data that the registry has submitted to CMS on behalf of its participating hospitals is accurate and complete.
- The registry must agree to provide at least 1 feedback report per year to participating hospitals;
- The registry must agree to provide on-going technical assistance to its participating hospitals with respect to the hospitals' submission of RHQDAPU data; and
- The registry must agree to participate in periodic RHQDAPU program support calls hosted by CMS.

To apply to be a qualified registry for any of the four proposed registry-based topics, a registry must submit a self-nomination letter by October 15, 2010 to *RHQDAPU_Registries@cms.hhs.gov* containing the registry name, point of contact, the proposed registry-based measure topic for which qualification is being sought, and detailed information regarding how the registry satisfies the criteria listed above.

B. Payment for Transfers of Cases From Medicare Participating Acute Care Hospitals to Nonparticipating Hospitals and CAHs (§ 412.4)

1. Background

Existing regulations at § 412.4(a) provide that an inpatient is considered discharged from a hospital paid under the IPPS when the patient is either formally released from the hospital or dies in the hospital. Under certain circumstances, a discharge is considered a transfer for purposes of payment under the IPPS. Section 412.4(b) defines acute care transfers, and § 412.4(c) identifies those discharges considered a postacute care transfer. In accordance with § 412.4(f), when a patient is transferred and his or her length of stay is less than the geometric mean length of stay for the MS–DRG to which the case is assigned, the transferring hospital is generally paid based on a graduated per diem rate for each day of the stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred. In the case of acute care transfers, the receiving hospital that ultimately discharges the transferred patient receives the full MS–DRG payment, regardless of whether the length of the patient's inpatient stay exceeds the geometric mean length of stay for the applicable MS–DRG.

The per diem rate paid to a transferring hospital is calculated by dividing the full MS–DRG payment by the geometric mean length of stay for the MS–DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 5804), our policy generally provides for payment that is double the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full DRG payment (§ 412.4(f)(1)). Transfer cases also are eligible for outlier payments. In general, the outlier threshold for transfer cases, as described in § 412.80(b) of the regulations, is equal to the fixed-loss outlier threshold for nontransfer cases (adjusted for geographic variations in costs), divided by the geometric mean length of stay for the MS–DRG, and multiplied by the length of stay for the case plus one day.

The transfer policy adjusts the payments of the transferring hospital to approximate the reduced costs of transfer cases. Medicare adopted its IPPS transfer policy because, if Medicare were to pay the full MS–DRG payment regardless of whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in their stay in order to minimize costs while still receiving the full MS–DRG payment.

b. Proposed Policy Change

The regulations at § 412.4(b) state that a discharge of a hospital inpatient is considered to be an acute care transfer when the patient is readmitted on the same day to another hospital that is paid under the IPPS, or to a hospital that is excluded from the IPPS because of participation in a statewide cost control program, unless the readmission is unrelated to the initial discharge. These regulations were developed under the authority granted in section 1886(d)(5)(I)(ii) of the Act. Because a discharge is only considered an acute care transfer if the receiving hospital either is paid under IPPS or participates in a statewide cost control program, the current acute care transfer policy only applies to transfers between acute care hospitals that participate in the Medicare program ("participating acute care hospitals"); it does not currently apply to acute care hospitals that would otherwise be eligible to be paid under the IPPS, but do not have an agreement to participate in the Medicare program ("nonparticipating acute care hospitals"). The acute care transfer policy also does not currently apply to IPPS acute care hospital transfers to CAHs.

The intent of the acute care transfer policy is to make payment to the transferring hospital commensurate with the resources it expends in treating Medicare beneficiaries. As stated above, a participating acute care hospital that admits a beneficiary from a transferring hospital receives a full MS–DRG payment, as long as the receiving hospital does not subsequently transfer the beneficiary prior to the geometric mean length of stay for that MS–DRG. The transferring hospital receives a reduced per diem payment amount. If the acute care transfer policy did not exist, Medicare would make separate full MS–DRG payments to each of the hospitals involved with the treatment of the beneficiary, even though the hospitals shared in one episode of care for the same beneficiary and neither provided the full spectrum of care for that beneficiary for that episode of care. Such a policy would inappropriately pay a "double" Medicare payment and would be inconsistent with the intent of the acute care transfer policy.

Although a nonparticipating acute care hospital is generally ineligible to receive payments under Medicare, such a hospital may still treat Medicare patients. In addition, acute care hospitals that do participate in the Medicare program are not precluded from transferring a Medicare patient to a nonparticipating acute care hospital. We note that a hospital that transfers a patient early in the patient's stay (that is, prior to the geometric mean length of stay of the patient's MS–DRG) incurs reduced costs for that case, regardless of whether the patient is transferred to a Medicare participating acute care hospital or a nonparticipating acute care hospital. A hospital that sends such a transfer to a CAH incurs similarly reduced costs, despite the fact that transfers to CAHs are not currently included under the Medicare acute care transfer policy.

These policy changes are also being proposed in order to avoid creating a financial incentive for an IPPS hospital to transfer cases to one type of provider versus another. A transfer decision should be made based on the clinical merits of the beneficiary's situation and the transferring hospital's capabilities. More pointedly, we want to avoid providing a Medicare participating acute care hospital with an incentive to transfer cases to a nonparticipating acute care hospital or a CAH. Without a policy change, these incentives still exists as payment issues relating to the IPPS transfer policy. With respect to nonparticipating acute care hospitals, it is frequently explained that the Medicare conditions of participation provide a certain minimum standard of care that beneficiaries can expect, and that Medicare does not make payments to nonparticipating acute care hospitals because these hospitals do not commit to adhering to these conditions of participation. As such, the lack of a policy with regard to transfers to nonparticipating acute care hospitals results in an inappropriate payment incentive.

Accordingly, in order to further align the IPPS regulations relating to transfer of cases under § 412.4(b) with its original intent (that is, that a hospital's payment should be commensurate with the resources it expends for the case), in this proposed rule, we are proposing to add a new paragraph (b)(3) to § 412.4 to specify that an acute care hospital "transfer case" includes a transfer to an acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program, and a new paragraph (b)(4) to state that an acute care hospital "transfer" also includes a transfer to a CAH.

Hospitals must use patient discharge status code "66" (Discharged/Transferred to a Critical Access Hospital) on IPPS claims to identify transfers to CAHs. For transfers to nonparticipating acute care hospitals, hospitals must continue to use patient status code "02" (Discharged/Transferred to a Short-Term General Hospital for Inpatient Care) on IPPS claims. We note that the National Uniform Billing Committee (NUBC) periodically updates or changes patient status codes; therefore, hospitals should check NUBC guidance periodically to determine whether there have been any changes to these codes.

C. Technical Change to Regulations

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43939 through 43940), in response to public comments we received on the FY 2010 proposed rule relating to the effects on CAH status arising from the redesignation by OMB of three Micropolitan Statistical Areas as MSAs, we amended our regulations at § 485.610 by adding a paragraph (b)(4) to provide for a transition period for the CAHs that are located in counties that are reclassified from rural to urban to obtain a rural redesignation. However, when we added the new paragraph (b)(4) to § 485.610, we inadvertently failed to make a conforming change to the introductory text of paragraph (b) to include a reference to paragraph (b)(4) as one of the requirements that the CAH must meet in order to satisfy the conditions of participation for CAHs.

We are proposing to make this confirming change.

D. Medicare-Dependent, Small Rural Hospitals (MDHs): Change to Criteria (§ 412.108)

1. Background

Under the IPPS, separate special payment protections are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (that is, not less than 60 percent of its inpatient days or discharges either in its 1987 cost reporting year or in two of its most recent three settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are at 42 CFR 412.108.

Although MDHs are paid under an adjusted payment methodology, they are still IPPS hospitals paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate based on the hospital's FY 1982 or FY 1987 costs per discharge, whichever of these hospital-specific rates is higher. Section 5003(b) of Public Law 109–171 (DRA 2005) amended section 1886(d)(5)(G) of the Act to provide that, for discharges occurring on or after October 1, 2006, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these hospital-specific rates is highest.

For each cost reporting period, the fiscal intermediary or MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary or MAC makes the determination. However, it may not be possible for the fiscal intermediary or MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment or the IME adjustment, all of which are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The fiscal intermediary or MAC makes a final adjustment at the settlement of the cost report after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital.

If a hospital disagrees with the fiscal intermediary's or the MAC's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the determination in accordance with the procedures set forth in 42 CFR Part 405, Subpart R, which govern provider payment determinations and appeals.

2. Medicare-Dependency: Counting Medicare Inpatients

Currently, in order for an IPPS hospital to qualify as an MDH, at least 60 percent of its inpatient days or discharges must be attributable to individuals receiving Medicare Part A benefits (§ 412.108(a)(1)(iii) of the regulations).

The MDH policy, as explained in the FY 1991 final rule (55 FR 35994 through 35998), does not include in the count of Medicare inpatients those Medicare beneficiaries who have exhausted their Medicare Part A inpatient benefits. Currently, for purposes of determining DSH payment adjustments under the IPPS, section 1886(d)(5)(F)(vi)(I) of the Act and our policy include, in the Medicare inpatient count, individuals entitled to Medicare Part A benefits, regardless of whether or not they have exhausted Medicare Part A coverage. This policy is discussed in the FY 2005 IPPS final rule (69 FR 49090 through 49099). In addition, section 1886(d)(5)(G)(iv)(IV) of the Act specifies that a hospital is Medicare-dependent if "not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A." The use of the word "entitled" in the statute would encompass individuals who are entitled to Medicare Part A even though they have exhausted their Part A hospital days. Individuals who have exhausted their Part A inpatient benefit coverage remain "entitled" to Medicare Part A because they retain the Medicare Part A insurance benefit coverage (for example, covered SNF days), and they continue to meet all statutory criteria for entitlement to Part A benefits under section 226 of the Act (Entitlement to Hospital Insurance Benefits).

Accordingly, we are proposing to revise the Medicare-dependency criterion at § 412.108(a)(1)(iii) of the regulations to replace the term "receiving" with the phrase "entitled to". As a result, we would include in the count of Medicare inpatient days or discharges all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A inpatient hospital coverage benefit, as well as individuals enrolled in Medicare Advantage plans and section 1876 cost contracts, that is, health maintenance organizations (HMOs) and competitive medical plans (CMPs). We note that, for inpatient care provided to Medicare Part A beneficiaries enrolled with an HMO or a CMP, we provided that the days and discharges for those stays are counted for purposes of determining Medicare-dependency for MDH purposes (55 FR 35995). This was the case when HMOs and CMPs were included under Medicare Part A, and continues to be the case since 1997 when HMOs and CMPs were placed under Medicare Part C.

E. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges that occurred before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount (as discussed in the FY 1993 IPPS final rule (59 FR 45404 through 45409)). Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

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

Section 4202(b) of Public Law 105–33 states, in part, "[a]ny hospital classified as an RRC by the Secretary * * * for fiscal year 1991 shall be classified as such an RRC for fiscal year 1998 and each subsequent year." In the August 29, 1997 IPPS final rule with comment period (62 FR 45999), CMS reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification. However, CMS did not reinstate the status of hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. Subsequently, in the August 1, 2000 IPPS final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban, to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy all of the other applicable criteria. We use the definitions of "urban" and "rural" specified in Subpart D of 42 CFR Part 412. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). (We refer readers to § 412.96(c)(1) through (c)(5) and the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index (CMI)

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The proposed national median CMI value for FY 2011 includes data from all urban hospitals nationwide, and the proposed regional values for FY 2011 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). These proposed values are based on discharges occurring during FY 2009 (October 1, 2008 through September 30, 2009), and include bills posted to CMS' records through December 2009.

We are proposing that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, they must have a CMI value for FY 2009 that is at least—

- 1.5127; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed median CMI values by region are set forth in the following table:

Region	Proposed Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.3010
2. Middle Atlantic (PA, NJ, NY)	1.3590
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4559
4. East North Central (IL, IN, MI, OH, WI)	1.4262
5. East South Central (AL, KY, MS, TN)	1.3776
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4404
7. West South Central (AR, LA, OK, TX)	1.5181
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6004
9. Pacific (AK, CA, HI, OR, WA)	1.4826

The preceding numbers will be revised in the FY 2011 IPPS final rule to the extent required to reflect the updated FY 2009 MedPAR file, which will contain data from additional bills received through March 2010.

A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its fiscal intermediary or MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional

numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2008 (that is, October 1, 2007 through September 30, 2008), which are the latest cost report data available at the time this proposed rule was developed.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, must have, as the number of discharges for its cost reporting period that began during FY 2008, at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table.

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,701
2. Middle Atlantic (PA, NJ, NY)	11,346
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,905
4. East North Central (IL, IN, MI, OH, WI)	9,329
5. East South Central (AL, KY, MS, TN)	5,902
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,091
7. West South Central (AR, LA, OK, TX)	6,264
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,346
9. Pacific (AK, CA, HI, OR, WA)	8,464

These numbers will be revised in the FY 2011 IPPS final rule based on the latest available cost report data.

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

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2010, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2008.

F. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

Public Law 105–33 (BBA 1987) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2011

The IME adjustment to the MS–DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Public Law 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment. Prior to the enactment of Public Law 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. In the FY 2005 IPPS final rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2011, the formula multiplier is 1.35. We estimate that application of

this formula multiplier for the FY 2011 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

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

We refer readers to section IV.H.2. and IV.H.3. of the preamble of this proposed rule for a discussion of proposed changes to the policies for identifying "approved medical residency programs" and the electronic submission of Medicare GME affiliation agreements.

G. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs): Supplemental Security Income (SSI) Fraction (§ 412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. The Act specifies two methods by which a hospital may qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to needy patients with low incomes. This method is commonly referred to as the "Pickle method."

The second method for qualifying for the DSH payment adjustment, which is the most common, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of two fractions: The "Supplemental Security Income (SSI) fraction" and the "Medicaid fraction." The SSI fraction (also known as the "SSI ratio" or the "Medicare fraction") is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan) and SSI benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan). The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Because the DSH payment adjustment is part of the IPPS, the DSH statutory references (under section 1886(d)(5)(F) of the Act) to "days" apply only to hospital acute care inpatient days. Regulations located at 42 CFR 412.106 govern the Medicare DSH payment adjustment and specify how the DPP is calculated as well as how beds and patient days are counted in determining the DSH payment adjustment. Under § 412.106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the IME adjustment under § 412.105(b).

2. CMS' Current Data Matching Process for the SSI Fraction

From the inception of the Medicare DSH adjustment in 1986, CMS (formerly HCFA) has calculated the SSI fraction for each acute care hospital paid under the IPPS. This fraction, in combination with the Medicaid fraction, is used to determine whether the provider qualifies for a DSH payment adjustment and the amount of any such payment (51 FR 16772, 16777, May 6, 1986 interim final rule). In determining the number of inpatient days for individuals entitled to both Medicare Part A and SSI, as required for calculation of the numerator of the SSI fraction, CMS matches the Medicare records and SSI eligibility records for each hospital's patients during the Federal fiscal year, unless the provider requests calculation of the SSI fraction on a cost reporting period basis (in which case the provider would receive its SSI fraction based on its own cost reporting period). The data underlying the match process are drawn from: (a) The Medicare Provider Analysis and Review (MedPAR) data file; and (b) SSI eligibility data provided by the Social Security Administration (SSA). CMS has matched Medicare and SSI eligibility records using Title II numbers (included in the SSI records) and Health Insurance Claims Account Numbers (HICANs) (contained in the MedPAR file). Below we provide a more detailed description of both a Title II number and a HICAN.

Title II Number: If a person qualifies for retirement or disability benefits under Title II of the Act (42 U.S.C. 401 *et seq.*), SSA assigns a "Title II number" to the individual. If the Title II beneficiary's own earnings history (or the individual's disability) were the basis for such benefits, the person's Social Security number (SSN) would constitute the "root" of the individual's Title II number. However, if the person's Title II benefits were based on the earnings history of another individual (for example, a spouse), that other person's SSN would provide the root for the beneficiary's Title II number. In addition to a root SSN, each Title II number ends with a Beneficiary Identification Code (BIC) that identifies the basis for an individual's entitlement to benefits. For example, a person who becomes eligible for benefits under his or her own account would be described by his or her SSN followed by the BIC "A" whereas a wife who becomes eligible for benefits under her husband's account would be described by his SSN followed by the BIC "B." Children who become eligible under a parent's account would be described by the parent's SSN followed by the BIC "C1," "C2," etc.

HICAN: When a person becomes entitled to Medicare benefits, he or she is assigned a HICAN for purposes of processing claims submitted on his or her behalf for Medicare services. A beneficiary's HICAN (which may not necessarily contain his or her SSN) is included on the Medicare inpatient hospital claim.

Each HICAN for a beneficiary should be identical, at the same point in time, to that individual's Title II number. This is because HICANs and Title II numbers are both assigned on the basis of the same data source, the SSA-maintained Master Beneficiary Record, and by using the same rules (that is, the rules for determining which person's SSN will serve as the root for an individual's HICAN and Title II number and for determining the BIC for both types of numbers).

We note that a person's Title II number and HICAN can change over time. For example, if the individual's entitlement to Title II and Medicare benefits was originally based on the earnings history of a first spouse, but the beneficiary later qualified for such benefits on the basis of a second spouse's earnings history, the beneficiary's HICAN and Title II number would change accordingly. Specifically, the first spouse's SSN would be the root of the beneficiary's original HICAN and Title II number; later, the second spouse's SSN would become the root of the beneficiary's second HICAN and Title II number.

The SSI eligibility data that CMS receives from SSA contain monthly

indicators to denote which month(s) each person was eligible for SSI benefits during a specific time period. The current matching process uses only one Title II number (which is included in the SSI file) and one HICAN (found in the MedPAR file) for each beneficiary. In the current matching process, CMS has used the HICAN because it is the patient identifier that is provided by hospitals on the Medicare claim. Because SSNs are not included on Medicare inpatient claims, CMS has not used SSNs in the match process.

For a given fiscal year, CMS determines the numerator of the hospital's SSI fraction (that is, the number of the hospital's inpatient days for all of its patients who were simultaneously entitled to Medicare Part A benefits and SSI benefits) by calculating the sum of the number of the hospital's inpatient days that are associated with all of the identical Title II numbers and HICANs for the hospital's claims that are found through the data matching process. In turn, CMS determines the denominator of the hospital's SSI fraction by calculating the sum of the number of the hospital's inpatient days for patients entitled to benefits under Medicare Part A (regardless of SSI eligibility) that are included in the hospital's inpatient claims for the period.

3. *Baystate Medical Center* v. *Leavitt Court Decision*

In *Baystate Medical Center* v. *Leavitt,* 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008), the district court concluded that, in certain respects, CMS' current matching process (as described above) did not use the "best available data" to match Medicare patient day information with SSI eligibility data when calculating the plaintiff's SSI fractions for FYs 1993 through 1996. Specifically, the court found that:

- Stale SSI Records and Forced Pay SSI Records. For the earliest years in question in *Baystate,* the SSI eligibility data did not include "stale" records—that is, records for individuals whose SSI records were no longer active from SSA's perspective. (We note that it is our understanding that, as of the year 2000, SSA no longer differentiates between inactive and active records and therefore, no longer uses the "stale record" indicator in its databases.) The court also found that the SSI data file only included SSI eligibility information for SSI payments that were automated (as opposed to manual), thereby excluding those people who, for whatever reason, received manual or "forced pay" payments. *Baystate,* 545 F. Supp. 2d at 44–46.
- Match Based on Only One Title II Number and One HICAN. The court found fault with CMS' use of only a single Title II number and one HICAN in the match process. As a beneficiary may receive SSI and Medicare Part A benefits under more than one Title II number and HICAN over a period of time, CMS would not have matched a beneficiary's records if there had been a change in the person's Title II number and HICAN between the time of an inpatient stay and when the match process was completed. *Baystate,* 545 F. Supp. 2d at 46–49.
- Retroactive SSI Eligibility Determinations and Lifting of Payment Suspensions. The court found that the match process did not appropriately account for retroactive eligibility determinations of SSI eligibility and the lifting of payment suspensions because the match process used SSI eligibility data that did not include more recent retroactive determinations of SSI eligibility and the lifting of SSI payment suspensions. By not using more recent SSI eligibility information that was available to CMS at the time of the hospital's cost report settlement, the court concluded that CMS did not use the "best available data" to calculate the provider's SSI fraction. *Baystate,* 545 F. Supp. 2d at 42–44.

CMS continues to believe that its current data matching process and the resultant SSI fraction and DSH payments were lawful. Nonetheless, the agency did not appeal the *Baystate* decision. Accordingly, CMS implemented the court's decision by recalculating the plaintiff's SSI fractions for 1993 through 1996. In recalculating the SSI fractions at issue in the *Baystate* case, we worked closely with SSA to ensure that stale and forced pay SSI records were included in the SSI eligibility data. Also, we used a revised data matching process (described in more detail below) that comports with the court's decision. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, we are proposing to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.

4. CMS' Proposed Process for Matching Medicare and SSI Eligibility Data

a. Inclusion of Stale Records and Forced Pay Records in the SSI Eligibility Data Files

In recalculating the SSI fractions at issue in the *Baystate* case, stale records and forced pay records were included in the SSI eligibility data files that CMS used in the revised data match for the four fiscal years at issue. All SSI payment records, whether the payments were automated or manual or were for an individual whose record was active or stale, are now included in the data files provided by SSA and will continue to be included in the future.

b. Use of SSNs in the Revised Match Process

As indicated above, the current matching process only uses one Title II number and one HICAN in the data match process. By contrast, our revised match process would make use of the Medicare Enrollment Database (EDB), which is CMS' system of records for all individuals who have ever been enrolled in Medicare. The EDB includes SSNs as well as all of an individual's HICANs. In our proposed revised match process, the individual's SSN, contained in the SSI eligibility data file, would be compared to the SSNs in the Medicare EDB, and each matched SSN would then be "cross-walked" within the EDB to find any and all HICANs associated with the individual's SSN. The resulting HICANs would then be matched against those HICANs contained in the MedPAR claims data files.

Before explaining our proposed revised match process in more detail, we believe it is appropriate to provide some background regarding SSNs and the three databases that would be used in our proposed match process. An individual should have only one SSN, which should be unique to that individual. The SSN may be assigned by SSA when the individual begins gainful employment (if not earlier). However, if an applicant for SSI benefits does not already have a SSN, SSA then assigns a SSN to the person. Thus, in the SSI eligibility data that SSA provides to CMS, each individual identified in those data should have a unique SSN.

The first database that we are proposing to use in our revised match process is the SSI eligibility data file, which contains a unique SSN for every SSI record and would include as many as 10 different historical Title II numbers for the records related to one individual. We are proposing to use 10 as the maximum number of Title II numbers for a beneficiary because that

is likewise the maximum number of HICANs that can be attributed to any one individual in our EDB. However, we note that as a practical matter, the greatest number of historical HICANs associated with any beneficiary appears to be 7. The SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI benefits.

The second relevant database, the Medicare EDB, contains a SSN for virtually every record in the EDB. Furthermore, the EDB has the capacity to hold up to 10 historical HICANs for a specific Medicare enrollee. (It is important to note that, of the more than 100 million records in the EDB, less than 0.07 percent (that is, fewer than 7 of every 10,000 records) relate to individuals for whom the EDB does not include a SSN for the person. The EDB might not include a SSN for an individual if, for example, the person lives in another country but is entitled to Medicare benefits through his or her spouse.)

The third relevant database that we are proposing to use in our revised match process is the MedPAR file. Hospitals submit claims to Medicare for inpatient services provided to Medicare beneficiaries. These claims are eventually accumulated in the MedPAR database. It is important to note that the MedPAR database does not contain SSNs. The MedPAR database contains one HICAN number for each and every record of services provided to a Medicare beneficiary who was admitted to a Medicare-certified hospital or skilled nursing facility. This database allows us to calculate the number of Medicare inpatient hospital days, which we use in determining each hospital's DSH SSI fraction.

Utilizing the steps set forth below, we are proposing to use these three databases in a revised match process for FY 2011 and subsequent fiscal years:

Step 1—Use SSNs to find any and all relevant HICANs. Using the SSI eligibility data file provided by SSA, we are proposing to compare the individual SSNs in that file to the SSNs contained in the Medicare EDB. Each matched SSN would then be "cross-walked" (within the EDB) to find any and all HICANs associated with the individual's SSN. The resulting HICANs would then be matched against those HICANs contained in the MedPAR claims data files. This process should identify all relevant SSI records in which a SSN is associated with an individual who is simultaneously enrolled in Medicare Part A and in the SSI program.

Step 2—Utilize any and all Title II numbers. In order to provide further assurance that all of the Title II numbers and HICANs for SSI-eligible individuals have been identified, next we are proposing to compare the complete list of Title II numbers from the SSI data file (up to 10 Title II numbers for any one individual) to the list of HICANs generated through Step 1 above. If the SSI data file includes any Title II numbers that were not already identified in Step 1, the Title II number will be included in our revised match process and compared to any and all HICANs in MedPAR. We note that by including this second step (that is, adding all Title II numbers not previously identified by Step 1), we are addressing the very small universe of individuals for whom the EDB does not include a SSN. If an individual is entitled to SSI benefits and Medicare benefits, the new format of the SSI eligibility file will contain up to 10 Title II numbers and, if they have not already been captured, each of those numbers will be included in our revised match process. Even if an individual does not have a SSN in the EDB, this second step should ensure that our revised match process will include that individual.

Step 3—Ensure consistency between the HICANs in the EDB, Title II numbers, and the HICANs in the MedPAR file. The EDB stores the beneficiary's record at the most specific level of detail. For example, if the beneficiary's Medicare eligibility was originally based on a spouse's earnings history and the spouse subsequently dies, the beneficiary would have two HICANs. Both HICANs, which would have the same root, but different BICs, would be stored in the EDB. However, the inpatient claim in the MedPAR file will only have the individual's HICAN at a more general level of detail; in the preceding example, the BIC would identify the beneficiary only as a spouse without specifying whether the spouse (that is, the "primary" beneficiary) was alive or deceased. This third step should ensure consistency between the HICANs from Step 1 and the Title II numbers from Step 2 by "equating" (or converting) the BIC identifiers to the identifiers that are on the inpatient claim that is included in the MedPAR file. In addition, we are proposing that, for any SSI-eligible beneficiary who is receiving Medicare benefits based on his or her own account but whose records have not been matched already, we will attempt to match the beneficiary's HICAN in the MedPAR file. Specifically, we are proposing to simply add an "A" to all the SSNs in the SSI eligibility data file so that, if that individual was not captured by Steps 1 and 2 above (for whatever unlikely reason) but MedPAR indicated that the person had received Medicare services, the individual would be included in the data match process by this third step.

Step 4—Calculate the SSI fraction. We are not proposing any changes with respect to the final step in determining the SSI fraction. To calculate the numerator of the SSI fraction, CMS would continue to sum a hospital's Medicare inpatient days in the acute care part of the hospital (excluding IPPS-exempt units such as rehabilitation and psychiatric units) where the Medicare beneficiary was simultaneously entitled to SSI benefits. To calculate the denominator, CMS would continue to sum a hospital's total Medicare inpatient days in the acute care part of the hospital.

c. Timing of the Match

One of the district court's findings in the *Baystate* decision was that CMS did not use the latest available SSI eligibility file to calculate the provider's SSI fractions. As a result, it might be possible that if a beneficiary treated at the hospital was later determined retroactively to be SSI eligible or if a suspension of the individual's SSI payments was later lifted, that inpatient stay might not be included in the numerator of the SSI fraction. We believe that, in our recalculation of the *Baystate* hospital's SSI fractions and DSH payments, retroactive SSI eligibility determinations and the lifting of SSI payment suspensions were not an issue due to the long period of time that elapsed between the provider's 1993 through 1996 fiscal years and our use of updated SSI eligibility data during our completion of the revised match process in 2009. However, we believe that further consideration of the timing of both the SSI eligibility information that SSA provides to CMS and our proposed revised match process for FY 2011 and subsequent fiscal years is warranted.

At present, SSA provides an annual file to CMS with SSI eligibility information that is current through March 31, or 6 months after the end of the prior Federal fiscal year on September 30 (70 FR 47278, 47440, August 12, 2005). Based on this date, for a hospital with an October 1 to September 30 cost reporting period, the SSI eligibility information we currently use contains 6 to 18 months worth of retroactive SSI eligibility determinations and payment suspension closures—6 months from September (that is, the end of the cost reporting period) and 18 months from October (that is, the

beginning of the cost reporting period). The time lag between the close of a hospital's cost reporting period and the date that CMS receives SSI eligibility information could actually be longer or shorter for some hospitals, depending on the hospital's specific cost reporting period. We note that SSI fractions are generally based on the Federal fiscal year. However, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.

As we stated in the FY 2006 final IPPS rule, we believe that administrative finality with respect to the calculation of a hospital's SSI fraction is important (70 FR 47440). We continue to believe that it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement. Further, we believe it is important to account for the time period in which hospitals are allowed to submit timely Medicare claims in order to ensure that the point in time that we perform the match process includes as many timely submitted inpatient hospital claims as are administratively practicable.

In accordance with the regulations at 42 CFR 424.44 and the Medicare Claims Processing Manual (Pub. L. 100–04), Chapter 1, Section 70, a hospital must generally file a claim by December 31 of the following year (for services furnished during the first 9 months of a calendar year) and by December 31 of the second following year (for services provided during the last 3 months of the calendar year). Therefore, Medicare claims for hospital services furnished in FY 2011 would have to be submitted no later than December 31, 2012. We note that section 6404 of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended, recently changed these deadlines to no more than "1 calendar year after the date of service" effective for services provided on or after January 1, 2010.

Generally speaking, providers have a financial incentive to submit fee-for-service claims as close as possible to the date of the patient's discharge, and providers have no incentive to wait until after the end of the fiscal year. Thus, while conducting a data match with MedPAR files that were updated 6 months after the end of the Federal fiscal year may not capture all of a provider's Medicare inpatient claims, we believe that, in large part, the provider's fee-for-service claims are included in that MedPAR file. The same may not be true for the "information only" or "no pay" claims that hospitals are required to submit to their fee-for-service contractor for Medicare Advantage (MA) beneficiaries. Because claims for MA beneficiaries are paid by MA plans and not the fee-for-service contractor, hospitals may not have the same incentive to file these claims as close as possible to the date of the patient's discharge.[14] However, in accordance with Transmittal 1396 (issued December 14, 2007) and Transmittal 1695 (issued March 6, 2009), which changed the instructions in the Medicare Claims Processing Manual (Pub. L. 100–04), all IPPS hospitals that do not qualify for IME payments, direct GME payments, or nursing and allied health (N&AH) payments are required to submit informational-only claims for all MA inpatients to ensure that data for MA beneficiaries is included in the SSI fraction. Accordingly, we also are considering changes to the timing of the data match process to ensure that all of a hospital's MA claims are included in the revised matching process given the lack of incentives that exist to submit these claims as soon as possible after the time of the patient's discharge.

In addition, in matching eligibility records for Medicare beneficiaries and SSI recipients to calculate the SSI fractions for FY 2011 and future fiscal years, we are also proposing to use more recent SSI eligibility information from SSA and a more updated version of MedPAR that is likely to contain more claims data. We currently use SSI eligibility data and MedPAR claims data that are updated 6 months after the close of the Federal fiscal year. We are proposing to use, for FY 2011 and subsequent years, SSI eligibility data files compiled by SSA and MedPAR claims information that are updated 15 months after the close of each Federal fiscal year. This proposal would more closely align the timing of the match process with the timing of our requirements (described above) for the timely submission of claims. For example, to calculate the FY 2011 SSI fractions, we would use the December 2012 update of the FY 2011 MedPAR file (containing claims information for patient discharges between October 1, 2010 and September 30, 2011), and a December 2012 SSI eligibility file (containing FY 2011 SSI eligibility data updated through December 2012, with a lag time relative to the Federal fiscal year of between 15 and 27 months). We expect that the FY 2011 SSI fractions would be published around March 2013 and would be used to settle cost reports for cost reporting periods that began in FY 2011. In addition, we would continue our practice of using each hospital's latest available SSI fraction in determining IPPS interim payments from the time that the SSI fractions are published until the SSI fractions for the next fiscal year are published.

Under current law as amended by section 6404 of Public Law 111–148, Medicare inpatient claims for FY 2011 can be submitted no later than 1 calendar year from the date of service or by September 30, 2012, for claims with a September 30, 2011 date of service. Therefore, we believe that using the version of MedPAR that is updated 15 months after the end of the fiscal year would contain more accurate and complete inpatient claims information, as we would be using claims data from 3 months after the filing deadline for claims with a date of service occurring on the last day of the second preceding fiscal year. Furthermore, a later update of the SSI eligibility file would contain more accurate eligibility information and would account for all retroactive changes in SSI eligibility and the lifting of SSI payment suspensions through that date.

The FY 2011 SSI fractions will be used to determine the hospitals' Medicare DSH payments for cost reporting periods beginning in FY 2011 (that is, October 1, 2010 through September 30, 2011). The proposed timing of the data match for the SSI fractions, effective for FY 2011, would result in FY 2011 SSI fractions being published around March 2013 and would generally coincide with the final settlement of cost reports for cost reporting periods beginning in FY 2011.

We believe that, by calculating SSI fractions on the basis of SSI eligibility data and MedPAR claims data that are

[14] Teaching hospitals have an incentive to submit these claims because they receive an indirect medical education payment. The claims are also used for a teaching hospital's direct medical education payments. Non-teaching DSH hospitals do not have the same direct incentives to submit these claims but to the extent that the MA beneficiary is also SSI eligible, it would be to the hospital's advantage to ensure these claims are included in the match process. However, nonteaching DSH hospitals are required to submit MA claims for all MA beneficiaries, regardless of whether the beneficiaries were eligible for SSI benefits.

updated 15 months after the end of the Federal fiscal year, we would be using the best data available to us, given the deadlines for the submission and final settlement of Medicare cost reports. Cost reports must be submitted to the Medicare fiscal intermediary or MAC no later than 5 months after the end of the provider's cost reporting period; the fiscal intermediary or MAC must make a determination of cost report acceptability within 30 days of receipt of the provider's cost report (42 CFR 413.24(f)(2)(i) and 413.24(f)(5)(iii)). In accordance with the Medicare Financial Manual (Pub. 100–06), Chapter 8, Section 90, the fiscal intermediary or MAC is expected to settle each cost report that is not scheduled for audit within 12 months of the contractor's acceptance of the cost report. We believe that our proposed timing of the data match would achieve an appropriate balance between accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions using all timely submitted Part A inpatient claims, and facilitating administrative finality through the timely final settlement of Medicare cost reports.

EXAMPLE OF TIMELINE TO CALCULATE FY 2011 SSI FRACTIONS UNDER CURRENT POLICY

Cost reports that use the FY 2011 SSI ratios	Deadline for timely filing of claims	MedPAR file used	SSI eligibility file used	Cost reports normally accepted	Cost report final settlement	SSI fraction available
Cost reports beginning October 1, 2010 through September 30, 2011.	December 2012	March 2012 update of FY 2011 MedPAR.	March 2012 update of FY 2011 SSI eligibility.	Generally between March 2012 and February 2013.	Generally between March 2013 and February 2014.	Summer 2012.

EXAMPLE OF TIMELINE TO CALCULATE FY 2011 SSI FRACTIONS UNDER PROPOSED RULE

Cost reports that use the FY 2011 SSI ratios	Deadline for timely filing of claims	MedPAR file used	SSI eligibility file used	Cost reports normally accepted	Cost report final settlement	SSI fraction available
Cost reports beginning October 1, 2010 through September 30, 2011.	December 2012	December 2012 update of FY 2011 MedPAR.	December 2012 update of FY 2011 SSI eligibility.	Generally between March 2012 and February 2013.	Generally between March 2013 and February 2014.	Spring 2013.

5. CMS Ruling

The CMS Administrator has prepared a CMS Ruling that addresses three Medicare DSH issues, including CMS' process for matching Medicare and SSI eligibility data and calculating hospitals' SSI fractions. With respect to the data matching process issue, the Ruling requires the Medicare administrative appeals tribunal (that is, the Administrator of CMS, the PRRB, the fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor. The Ruling also explains how, on remand, CMS and the contractor will recalculate the provider's DSH payment adjustment and make any payment deemed owing. The Ruling further provides that CMS and the Medicare contractors will apply the provisions of the Ruling, on the data matching process issue (and two other DSH issues, as applicable), in calculating the DSH payment adjustment for each hospital cost reporting period where the contractor has not yet final settled the provider's Medicare cost report through the issuance of an initial notice of program reimbursement (NPR) (42 CFR 405.1801(a) and 405.1803).

More specifically, the Ruling provides that, for qualifying appeals of the data matching issue and for cost reports not yet final settled by an initial NPR, CMS will apply any new data matching process that is adopted in the forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. The data matching process provisions of the Ruling would apply to properly pending appeals and open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule).

The Ruling further states that, if a new data matching process is not adopted in the forthcoming FY 2011 IPPS final rule, CMS would apply to claims subject to the Ruling the same data matching process as the agency used to implement the Baystate decision by recalculating that provider's SSI fractions.

6. Clarification of Language on Inclusion of Medicare Advantage Days in the SSI Fraction of the Medicare DSH Calculation

In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our policy change to reflect the inclusion of the days associated with Medicare + Choice (now Medicare Advantage (MA)) beneficiaries under Medicare Part C in the SSI fraction of the DSH calculation. In that rule, we indicated that we were revising the regulation text at § 412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not make a change in the regulation text to conform to the preamble language. We also inadvertently did not propose to change § 412.106(b)(2)(iii) in the FY 2005 final rule, although we intended to do so. Accordingly, in the FY 2007 IPPS rule (72 FR 47384), we made a technical correction to amend the regulations at § 412.106(b)(2)(i) and to § 412.106(b)(2)(iii) to make them consistent with the preamble language of the FY 2005 IPPS final rule and to conform to the policy implemented in that rule. Section 412.106(b)(2)(i) of the regulations discusses the numerator of the SSI fraction of the Medicare disproportionate patient percentage (DPP) calculation, while § 412.106(b)(2)(iii) of the regulations discusses the denominator of the SSI fraction of the Medicare DPP.

We are aware that there might be some confusion about our policy to include MA days in the SSI fraction, specifically regarding whether we have

implied that MA beneficiaries are not actually "entitled to receive benefits under Part A" by using the word "or" in § 412.106(b)(2)(i)(B) and § 412.106 (b)(2)(iii)(B) with respect to MA days. We note that in the FY 2005 final rule, we stated that we believed that Medicare + Choice (now MA) beneficiaries are patients who are entitled to benefits under Medicare Part A. With respect to the change to the regulatory text that we intended to make in the FY 2005 IPPS final rule, we stated "* * * we are adopting a policy to *include* patient days for M+C beneficiaries in the Medicare fraction" (69 FR 49099) (emphasis added). In order to further clarify our policy that patients days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word "or" with the word "including" in § 412.106(b)(2)(i)(B) and § 412.106 (b)(2)(iii)(B).

H. Payments for Direct Graduate Medical Education (GME) (§ 413.75)

1. Background

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of hospital inpatient services. Section 1886(h) of the Act, as implemented in regulations at § 413.75 through § 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated annually for inflation.

Hospitals may receive direct GME and IME payments for residents in "approved medical residency training programs." Section 1886(h)(5)(A) of the Act defines an "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." Section 1886(h)(4)(F) of the Act established a limit on the number of allopathic and osteopathic FTE residents that a hospital may include in its FTE resident count for purposes of calculating direct GME payments. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

2. Identifying "Approved Medical Residency Programs"

Despite the fact that current policies regarding the counting of FTE residents for IME and direct GME purposes have been in effect since October 1985, we continue to receive questions as to whether certain residents are training in approved medical residency programs, and whether these residents should be included in the Medicare direct GME and IME FTE counts. Although the fundamental rules defining an approved medical residency training program seem straightforward, some confusion apparently exists regarding whether certain trainees in a teaching hospital should be included in the FTE count for IME and direct GME purposes, or whether certain trainees should be treated as physicians and should instead bill for their services under Medicare Part B. These questions arise most often with regard to subspecialty training and "fellows." It is important for hospitals to understand when each of these types of payment applies.

a. Residents in Approved Medical Residency Programs

As stated earlier, section 1886(h)(5)(A) of the Act defines an "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." The regulations at § 413.75(b) define an "approved medical residency program" as a program that meets *one* of the following criteria (emphasis added):

(1) Is approved by one of the national organizations listed in § 415.152 of the regulations.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

The regulations at § 415.152 define an "approved graduate medical education program" as a residency program approved by one of the following national organizations (or their predecessors): The Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, the American Osteopathic Association (AOA), the Commission on Dental Accreditation (CODA) of the American Dental Association, and the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. The statutory basis for this regulation is at section 1861(b)(6) of the Act, which cites these accrediting bodies for residency programs. Thus, in general, under § 413.75(b), an "approved" program can be a program that is accredited by one of these national organizations, or one that leads toward board certification by the American Board of Medical Specialties (ABMS). In the September 29, 1989 final rule (54 FR 40295), we explained that, in order to reconcile the two statutory definitions of approved programs at sections 1861(b)(6) and 1886(h)(5)(A) of the Act, we did not limit our regulatory definition of "approved medical residency program" to one that may count toward certification in a specialty, but added that a program is also "approved" for purposes of IME and direct GME if it is approved by one of the national accrediting bodies. Furthermore, we understood that, especially with respect to subspecialty training, there historically were some formal programs for which none of the listed national accrediting bodies had established standards. However, the ABMS had established a national board examination for some of those unaccredited programs and, consequently, those programs do count toward certification. Accordingly, such

programs also meet the definition of an "approved medical residency training program."

b. Determining Whether an Individual Is a Resident or a Physician

The statute and the regulations (in at least two places in the teaching context) define the term "resident." Section 1861(b)(6) of the Act refers to services provided in a hospital by an "intern or resident-in-training under a teaching program approved" by one of the listed accrediting bodies for residency programs. In addition, section 1886(h)(5)(I) of the Act states that the term "resident" includes "an intern or other participant in an approved medical residency training program." The regulations at § 413.75(b) state that the term resident means "an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

As discussed above, an "approved" program is one that is accredited by one of the listed national organizations, or one that may count towards board certification. Generally, residency programs today, whether they are core or subspecialty programs, are both accredited, and lead toward board certification through an explicit board examination for that field. Thus, in the typical instance, a resident is accepted into an accredited program in a particular specialty, completes that program over the course of what is typically 3 to 5 years, and then qualifies to take the board certifying examination in the particular specialty of that program. This resident may or may not train in an additional accredited subspecialty program, which would typically last for 1 to 3 years, and which would also lead to board certification through an additional board certifying examination which the individual would be qualified to take upon completion.

We receive questions from time to time regarding whether individuals are considered to be trainees in approved programs or whether they are considered to be physicians and should bill accordingly. These questions frequently involve programs of further training that certain senior and junior faculty at hospitals, typically at large academic medical centers, undertake on their own, not under the auspices of any accrediting body, and in an area of practice for which there is no board certification. Therefore, there is no actual standardized curriculum or formally organized "program" in which the individual trainee is participating. Another type of trainee about which we have received questions is one that has completed an accredited program in a certain specialty, but subsequently participates in additional training in that specialty that he or she could have participated in while still within the accredited program. Sometimes this individual may even train with residents who are actually still training in that accredited program (for example, an individual who has completed a dermatology residency may choose to do additional training with PGY4 dermatology residents). In these scenarios, in order to decide whether an individual is considered a resident or a physician for purposes of Medicare payment, the pertinent questions are whether—

(1) The individual actually needs the training in order to meet board certification requirements in that specialty; and

(2) Whether the individual is formally participating in an organized, standardized, structured course of study.

With regard to the junior faculty who are "training" with senior faculty to learn highly specialized skills, we believe that individuals participating in a course of training that one or more senior physicians creates absent the involvement and approval of an accrediting body, and for which there is no specific existing board certification examination, should not be considered "residents" or counted for IME and direct GME purposes. Similarly, individuals that already completed an accredited residency program, but subsequently participate in additional training in that same specialty that they could have participated in while still within that accredited program, should also not be considered "residents" or be included in the IME and direct GME count. This is because these individuals have already completed accredited residency programs in a particular specialty or subspecialty, and do not need to complete the additional training in order to meet board certification requirements in that field in which they continue to "train." The definition of "resident" at § 413.75(b) is "an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, *as required in order to become certified by the appropriate specialty board*" (emphasis added). Accordingly, the individuals described in the scenarios above do not meet the definition of "resident" at § 413.75(b) for IME and direct GME purposes. Instead, these individuals should be treated and receive payment as physicians.

As we explained in the September 29, 1989 **Federal Register** rule: "The costs relating to patient care services of licensed physicians who are classified as "fellows" but who are not in an identifiable formal program leading to certification as defined in section 1886(h)(5) of the Act but remain at a teaching hospital/medical school complex to enhance their expertise in a field of study are payable on a Part B reasonable charge basis [now under the Medicare physician fee schedule] as physicians' services" (54 FR 40295). Similarly, in the Provider Reimbursement Manual, Part I, section 2405.3.F.2, we state, "Intermediaries must not count an individual in the indirect medical education adjustment if * * * [A]n individual designated as a "fellow" has elected to remain at a teaching hospital/university complex for additional work to gain expertise in a particular field but is no longer in a formally organized program to *fulfill certification requirements.* The services of such an individual are generally covered as physicians' services payable on a reasonable charge basis" (emphasis added). (**Note:** Although we used the term "fellow," which is defined synonymously with "resident" in the regulations at § 413.75, in these paragraphs in the September 29, 1989 **Federal Register** and in the PRM–I, by stating that such "fellows" are not in identifiable, formally organized programs and their services should be billed under Part B as physician services, we clearly were indicating that these "fellows" are licensed physicians, not residents, and should not be included in the IME and direct GME FTE counts. Perhaps "junior faculty" would have been a more apt characterization of these individuals.)

The passage from the September 29, 1989 **Federal Register** also mentions an "identifiable formal program leading to certification as defined in section 1886(h)(5) of the Act" which refers to the statutory definition of "approved medical residency program." The word "approved" connotes formality; a planned, structured course of study with a curriculum based on national (rather than individual physician or hospital) standards with a standardized outcome based on standardized evaluations. Since the early days of Medicare, prior to the enactment of section 1886(h) of the Act, when hospitals received payment on a reasonable cost basis for "approved educational activities," we defined such activities as "*formally organized* or *planned* programs of study operated or

supported by an institution, *as distinguished from 'on-the-job,' 'inservice,' or similar work-learning programs*" (emphasis added) (PRM–I, section 402.1). We believe the education that junior faculty receive when working closely with senior faculty to gain highly specialized skills is more appropriately characterized as on-the-job, or inservice training, rather than training in an "approved medical residency program."

In order for the training to be considered an "approved medical residency program," the training must prepare the individual for certification in the particular specialty or subspecialty in which the individual is training. The mere possibility that the training could be construed as leading toward or counting toward certification in some existing board examination is insufficient. For example, an individual who is enrolled and participating in a two year accredited subspecialty program in allergy and immunology and, as part of that program, completes an elective in allergic reactions to insect stings is considered a resident during that elective, and may be included in the IME and direct GME FTE count (assuming all other requirements are met). However, if, after completion of the 2-year allergy and immunology subspecialty program, this individual decides to remain at the teaching hospital for a year to shadow a physician who has unique expertise in allergic reactions to insect stings, this individual would not be considered a resident, nor would this training be considered an approved program, because this individual is not formally enrolled in a planned, structured, standardized course of study, nor is this year of training required for any individual to qualify to take the board examination in allergy and immunology. This individual already completed the 2-year subspecialty program, and therefore, the extra year spent studying allergic reactions to insect stings is extraneous. Accordingly, this individual would not be viewed as a resident participating in an approved medical residency training program. Rather, this individual is considered a physician and should bill Medicare for services furnished under the physician fee schedule.

c. Formal Enrollment and Participation in a Program

We understand that the participation of individuals in an approved medical residency program under which they would be considered residents as defined at § 413.75 is marked by a formal application, acceptance, and enrollment process. We believe that in order for an individual to be considered a resident for purposes of inclusion in the IME and direct GME counts, whether the individual is a graduate of an allopathic medical school, an osteopathic medical school, or a school of podiatry or dentistry, the individual must be:

(1) Formally accepted and enrolled in the training program, and

(2) Fully participating in that training (unless there is a documented arrangement for the resident to work part time).

In general, we would expect formal acceptance to include an application process (for example, the national residency match process), and an enrollment process which would include letters or other official notifications from the hospital or program sponsor regarding the resident's acceptance to train in a particular program. We would also expect the resident to have an employment contract with the institution(s) sponsoring the program and/or the institution(s) in which he or she is training. A hospital must be able to document that the individual's participation in the particular course of training represents a definitive (not hypothetical) path for that individual's certification, and that satisfactory completion of such training would fulfill all required elements in order for the individual to qualify to take a specific board examination.

In order to make these rules clearer for the future, we are proposing to revise the definition of "resident" to specify that the trainee must be "formally accepted and enrolled" in the approved program in order to be considered a resident for IME and direct GME purposes. Specifically, we are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board." We also are proposing to make a similar conforming change to the definition of "primary care resident" at § 413.75(b). This change in the definitions of "resident" and "primary care resident" would be effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.

In summary, we are proposing to clarify that individuals participating in a specialized course of training created by a senior physician, and not under the auspices of a national accrediting body, and for which there is no explicit existing board certification examination, should not be counted for IME and direct GME purposes. Such individuals should be treated as physicians, and their services should be billed to Medicare for payment as physicians' services. If an individual has already successfully completed at least one residency program and has met the requirements to be board eligible in a specialty (regardless of whether the individual has passed the board examination for that specialty), and is engaged in subsequent training that will not provide additional knowledge or skills that could be applied for board certification in a subspecialty, the individual should be treated and bill for services provided as a physician. We also are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board." We are proposing to make a conforming change to the definition of "primary care resident" to mean "a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice." This change in the definitions of "resident" and "primary care resident" would be effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.

3. Electronic Submission of Affiliation Agreements

Sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic FTE residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment. In addition, under the authority granted by section 1886(h)(4)(H)(ii) of the Act, the Secretary issued regulations on May 12, 1998 (63 FR 26358) to allow institutions that are members of the same Medicare GME affiliated group to elect to apply their direct GME and IME FTE resident caps based on the aggregate cap of all hospitals that are part of a Medicare GME affiliation group. Under those regulations, specified at § 413.79(f) for direct GME and at § 412.105(f)(1)(vi) for IME, hospitals that are part of the same Medicare GME affiliated group are permitted to adjust each hospital's caps

to reflect the rotation of residents among affiliated hospitals during an academic year. Under § 413.75(b), a Medicare GME affiliated group may be formed by two or more hospitals if: (1) The hospitals are located in the same urban or rural area or in a contiguous area and have a shared rotational arrangement as specified at § 413.79(f)(2); (2) the hospitals are not located in the same or in a contiguous area, but have a shared rotational arrangement and they are jointly listed as the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most recent publication of the *Graduate Medical Education Directory,* or as the sponsor or is listed under "affiliations and outside rotations" for one or more programs in *Opportunities, Directory of Osteopathic Post-Doctoral Education Programs;* or (3) effective beginning July 1, 2003, two or more hospitals are under common ownership and have a shared rotational arrangement under § 413.79(f)(2).

The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the CMS fiscal intermediary or MAC servicing the hospital and send a copy of the agreement to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect. For example, in order for a hospital to receive a temporary adjustment to its FTE resident caps to reflect participation in a Medicare GME affiliated group for the academic year beginning July 1, 2009, through June 30, 2010, the hospital in the affiliated group had to submit a Medicare GME affiliation agreement to the fiscal intermediary or MAC servicing the hospital and send a copy of the agreement to CMS' Central Office no later than July 1, 2009.

Over the last several years, we have received numerous inquiries regarding the possibility of submitting the Medicare GME affiliation agreement electronically. To date, CMS has only accepted signed hard copies of Medicare GME affiliation agreements that are received through the mail. Facsimile (FAX) and other electronic submissions of affiliation agreements have not been acceptable means of transmission of affiliation agreements to CMS Central Office in order for a hospital to meet the requirements of §§ 413.79(f) and 412.105(f)(1)(vi).

The increasing frequency of these inquiries and our concerns regarding environmental and paperwork reduction have prompted us to reconsider our procedure for hospitals to submit Medicare GME affiliation agreements to the CMS Central Office. Accordingly, we are proposing to change our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. This proposal would not affect the authority of the fiscal intermediary or MAC to continue to specify its requirements for submission for hospitals in its servicing area.

We are proposing an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display (PDF) version of that hard copy agreement; we are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75.

We believe that allowing an electronic submission of the affiliation agreement to the CMS Central Office would assist us in more effectively tracking the groups of hospitals that affiliate as well as the numbers of FTE cap slots that are being transferred within those groups. In addition, we believe an electronic submission process would minimize the paperwork burden for hospitals.

I. Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs

Section 2312 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) provided for reimbursement to hospitals on a reasonable cost basis for the costs that hospitals incur in connection with the services of certified registered nurse anesthetists (CRNAs). Section 2312(c) provided that pass-through of CRNA costs was effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (which established a fee schedule for the services of nurse anesthetists) amended section 2312(c) of Public Law 98–369 by extending the CRNA pass-through provision through cost reporting periods beginning before January 1, 1989. In addition, Public Law 99–509 amended section 1861 of the Act to add a new subsection (bb), which provides that CRNA services include anesthesia services and related care furnished by a CRNA. Section 608 of the Family Support Act of 1988 (Pub. L. 100–485) extended pass-through payments for CRNA services through 1991 and amended section 9320 of Public Law 99–509 by including language referring to eligibility for pass-through payments for CRNA services if the facility is "* * * a hospital located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act) * * *." Reasonable cost-based payment for CRNA services was extended indefinitely by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

Section 1886(d)(2)(D) of the Act defines "rural" as any area outside an urban area. This definition of "rural" was in effect when Public Law 100–485 was implemented. In 1999, the Balanced Budget Refinement Act (Pub. L. 106–113) amended section 1886(d)(8) of the Act by adding a new subparagraph (E), which permits a hospital physically located in an urban area to apply for reclassification to be treated as rural. In addition, Public Law 106–113 made a corresponding change to section 1820(c)(2)(B)(i) of the Act, which specifies the location requirements for CAH designation, by adding the phrase "or is treated as being located in a rural area pursuant to section 1886(d)(8)(E)."

The regulations implementing pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists employed by a hospital or CAH, including CRNAs, are located at § 412.113(c). Section 412.113(c)(2)(i)(A) specifies the location requirement for facilities that furnish these services and are eligible to be paid based on reasonable cost for the services. The regulations require that the hospital or CAH be located in a rural area as defined at § 412.62(f) and not be deemed to be located in an urban area under the provisions of § 412.64(b)(3). The regulations at § 412.62(f) mirror section 1886(d)(2)(D) of the Act and define a rural area as "* * * any area outside an urban area." The regulations at § 412.64(b)(3) implement section 1886(d)(8)(B) of the Act, also known as the "Lugar" provision, which requires a hospital located in a rural county adjacent to one or more urban areas to be treated as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute.

Under existing regulations, neither CAHs/hospitals that have reclassified

from urban to rural under the regulations at § 412.103 nor CAHs/hospitals located in Lugar counties are eligible to receive pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists. We believe that because the statute, as revised by section 608 of Public Law 100–485, allows for reasonable cost payments for CRNA services if the facility is a hospital located in a rural area as defined for purposes of section 1886(d) of the Act, it is appropriate for us to make the regulations consistent by permitting urban hospitals that have been reclassified as rural to qualify for these payments. Therefore, we are proposing to revise § 412.113(c)(2)(i)(A) to state that effective for cost reporting periods beginning on or after October 1, 2010, CAHs and hospitals that have reclassified pursuant to section 1886(d)(8)(E) of the Act and § 412.103 of the regulations are also rural for purposes of section 1886(d) of the Act and, therefore, are eligible to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified nonphysician anesthetist.

We are not proposing to change our regulations to permit Lugar facilities to be paid based on reasonable cost for anesthesia services and related care furnished by qualified nonphysician anesthetists. As noted above, in order to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified nonphysician anesthetist, a hospital or CAH must be considered rural for purposes of section 1886(d) of the Act. Lugar facilities (facilities that have been reclassified under §§ 412.63(b)(3) and 412.64(b)(3)) are considered urban for purposes of section 1886(d) of the Act. As a result, we do not believe it would be consistent with the statute and our regulations to permit these facilities to be paid on a reasonable cost basis for anesthesia services and related care furnished by qualified nonphysician anesthetists.

J. Rural Community Hospital Demonstration Program

Section 410A(a) of Public Law 108–173 required the Secretary to establish a demonstration program to test the feasibility and advisability of establishing "rural community hospitals" to furnish covered inpatient hospital services to Medicare beneficiaries. The demonstration pays rural community hospitals for such services under a cost-based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH under section 1820 of the Act.

Section 410A(a)(4) of Public Law 108–173 (MMA) specified that the Secretary was to select for participation no more than 15 rural community hospitals in rural areas of States that the Secretary identified as having low population densities. Using 2002 data from the U.S. Census Bureau, we identified the 10 States with the lowest population density in which rural community hospitals were to be located in order to participate in the demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau, Statistical Abstract of the United States: 2003).

CMS originally solicited applicants for the demonstration in May 2004; 13 hospitals began participation with cost report years beginning on or after October 1, 2004. (Four of these 13 hospitals withdrew from the program and became CAHs). In a notice published in the **Federal Register** on February 6, 2008 (73 FR 6971), we announced a solicitation for up to 6 additional hospitals to participate in the demonstration program. Four additional hospitals were selected to participate under this solicitation. These four additional hospitals began under the demonstration payment methodology with the hospital's first cost reporting period starting on or after July 1, 2008. Three hospitals (2 of the hospitals were among the 13 hospitals that originally participated in the demonstration and 1 of the hospitals was among the 4 hospitals that began the demonstration in 2008) withdrew from the demonstration during CY 2009. (Two of these hospitals indicated that they will be paid more for Medicare inpatient services under the rebasing allowed under the SCH methodology allowed by the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275). The other hospital restructured to become a CAH.) There are currently 10 hospitals participating in the demonstration.

Section 410A(a)(5) of Public Law 108–173 required a 5-year demonstration period of participation. For the seven currently participating hospitals that began the demonstration during FY 2005, the demonstration was scheduled to end for each of these hospitals on the last day of its cost reporting period that ends in FY 2010. The end of the participation for the three participating hospitals that began the demonstration in CY 2008 was scheduled to be September 30, 2010. A 5-year extension of the demonstration was mandated in the Patient Protection and Affordable Care Act (PPACA, Pub. L. 111–148). We note that this proposed rule does not address the relevant changes mandated by Public Law 111–148. Public Law 111–148 does affect our proposed FY 2011 policy with regard to the rural community hospital demonstration. However, we will address that provision of Public Law 111–148 and any revised policy proposals in a separate rulemaking document in the **Federal Register**.

Section 410A of Public Law 108–173 required that, "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." This requirement is commonly referred to as "budget neutrality."

Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating hospitals do not exceed the amount that would be paid to those same hospitals in the absence of the demonstration program. Typically, this form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to participating small rural hospitals are likely to increase Medicare outlays without producing any

offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these same hospitals.

In the past six IPPS final regulations, spanning the period for which the demonstration has been implemented, we have adjusted the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program, thus applying budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, FY 2007, FY 2008, FY 2009, and FY 2010 IPPS final rules (69 FR 49183; 70 FR 47462; 71 FR 48100; 72 FR 47392; 73 FR 48670; and 74 FR 43922), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner.

In this proposed rule, in order to ensure that the demonstration in FY 2007 is budget neutral, we are proposing to incorporate a component into the adjustment factor to the FY 2011 national IPPS rates that would offset the amount by which the costs of the demonstration program, as indicated by settled cost reports beginning in FY 2007 for hospitals participating in the demonstration during FY 2007, exceeded the amount that was identified in the FY 2007 final rule as the budget neutrality offset for FY 2007. Specifically, we are proposing the following methodology: (1) Calculate the FY 2007 costs of the demonstration program according to the settled cost reports that began in FY 2007 for the then participating hospitals (which represent the third year in the demonstration for each of the then participating hospitals); (2) Subtract the amount that was offset by the budget neutrality adjustment for FY 2007 ($9,197,870) from the costs of the demonstration in FY 2007 as calculated in step 1; and (3) Calculate an adjustment factor for the standardized amount for FY 2011 based on the dollar amount calculated in step 2 of this proposed methodology. This factor would represent the component of the proposed overall budget neutrality offset amount for FY 2011 that accounts for the difference between the cost of the demonstration in FY 2007 and the amount of the budget neutrality adjustment published in the FY 2007 final rule.

With respect to the first step of this proposed methodology, we note that we are proposing to use settled cost reports beginning in FY 2007 for hospitals participating in the demonstration during FY 2007 because we believe that these settled cost reports correspond most accurately to FY 2007 and because all such costs reports also began in FY 2007. Therefore, we believe they correctly represent FY 2007 inpatient costs for the demonstration during that period. In addition, in the process of making adjustments comparing the demonstration's costs to the amounts estimated annually for the budget neutrality offset over the demonstration's entire period of performance, the cost amounts from these hospitals' cost reports correspond most precisely to FY 2007. In addition, the settlement process for the demonstration hospitals' third year cost reports, that is, cost reporting periods starting in FY 2007, has experienced a delay. Therefore, for this FY 2011 IPPS proposed rule, we are unable to calculate the costs of the demonstration corresponding to FY 2007 and as a result are unable to propose the specific numeric adjustment that would be applied to the national IPPS rates. However, we expect cost reports beginning in FY 2007 for hospitals that participated in the demonstration during FY 2007 to be settled before the FY 2011 IPPS final rule is published. Therefore, for the FY 2011 IPPS final rule, we will be able to calculate the amount by which the costs corresponding to FY 2007 exceeded the amount offset by the budget neutrality adjustment for FY 2007.

V. Proposed Changes to the IPPS for Capital-Related Costs

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate rulemaking documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and LTCH PPS.

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services "in accordance with a prospective payment system established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.) The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312 of the regulations. For the purpose of calculating payments for each discharge, currently the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

B. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was

originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the fiscal intermediary or MAC indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

C. New Hospitals

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

D. Hospitals Located in Puerto Rico

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

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

E. Proposed Changes for FY 2011: MS–DRG Documentation and Coding Adjustment

1. Background on the Prospective MS–DRG Documentation and Coding Adjustments for FY 2008 and FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize patients' severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. (Currently, there are 746 MS–DRGs, including one additional MS–DRG created in FY 2009. For FY 2011, there would be 747 DRGs with our proposals in this proposed rule to delete one MS- DRG and to create two new MS–DRGs.) By increasing the number of DRGs and more fully taking into account patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to change their documentation and coding of patient diagnoses. In that same final rule with comment period (72 FR 47183), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. Accordingly, we established adjustments to both the national operating standardized amount and the national capital Federal rate to eliminate the estimated effect of changes in documentation and coding resulting from the adoption of the MS–DRGs that do not reflect real changes in case-mix. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent

for FY 2010. However, to comply with section 7(a) of Public Law 110–90, enacted on September 29, 2007, in a final rule published in the **Federal Register** on November 27, 2007 (72 FR 66886 through 66888), we modified the documentation and coding adjustment for FY 2008 to −0.6 percent, and consequently revised the FY 2008 IPPS operating and capital payment rates, factors, and thresholds accordingly, with these revisions effective October 1, 2007.

For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As discussed in the FY 2008 IPPS final rule with comment period (72 FR 48447 and 48733 through 48774), we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts and the capital Federal rate. The documentation and coding adjustments established in the FY 2009 IPPS final rule, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent. (For additional details on the development and implementation of the documentation and coding adjustments for FY 2008 and FY 2009, we refer readers to section II.D. of this preamble and the following rules published in the **Federal Register**: August 22, 2007 (72 FR 47175 through 47186 and 47431 through 47432); November 27, 2007 (72 FR 66886 through 66888); and August 19, 2008 (73 FR 48447 through 48450 and 48773 through 48775).)

2. Retrospective Evaluation of FY 2008 Claims Data

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we presented the results of a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries determined that implementation of the MS–DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 (74 FR 24092 through 24101). We also sought public comment on our methodology and analysis and the proposed −1.9 percent prospective adjustment to address the effect of documentation and coding changes unrelated to changes in real case-mix in FY 2008 (that is, the estimated −2.5 percent documentation and coding effect for FY 2008 minus the −0.6 percent documentation and coding adjustment that was applied to the national capital Federal rate for FY 2008). In addition, we sought public comment on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied in determining the FY 2009 capital Federal rate established in the FY 2009 IPPS final rule. However, after consideration of the public comments received on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, consistent with the application of the documentation and coding adjustment to the operating IPPS standardized amounts, we determined that it would be appropriate to postpone the adoption of any additional documentation and coding adjustments to the capital IPPS rates until a full analysis of FY 2009 case-mix changes could be completed. We stated that although we only proposed to make a −1.9 percent adjustment to account for the portion of the estimated 2.5 percent change in FY 2008 case-mix due to documentation and coding changes that exceeds the −0.6 percent prospective documentation and coding adjustment applied to the FY 2008 capital Federal rate (that is, −2.5 percent minus −0.6 percent = −1.9 percent), our then current estimate of the MS–DRG documentation and coding effect for FY 2009 was 2.3 percent (that is, the 4.8 percent total increase minus the 2.5 percent increase from FY 2008). We indicated that if the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our then current estimates, it would change the anticipated cumulative adjustments that we then estimated we would have to make for FY 2008 and FY 2009 combined. We indicated that, in future rulemaking, we would consider applying a prospective documentation and coding adjustment to the capital IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data (74 FR 43926 through 43928).

3. Retrospective Analysis of FY 2009 Claims Data

For this proposed rule, we have performed a thorough retrospective evaluation of the most recent available claims data, and the results of this evaluation were used by our actuaries to determine any necessary payment adjustments beyond the cumulative −1.5 percent adjustment that has already been applied to the national capital Federal rate to ensure budget neutrality for the implementation of MS–DRGs. Specifically, as discussed in greater detail in section II.D.5. of the preamble of this proposed rule, we performed a retrospective evaluation of the FY 2009 claims data updated through December 2009 using the same analysis methodology as we did for FY 2008 claims in the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules. Based on this evaluation, our actuaries have determined that the implementation of the MS–DRG system resulted in a 5.4 percent change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009.

The 5.4 percent estimate of the cumulative effect of changes in documentation and coding under the MS–DRG system that did not reflect real changes in case-mix for FYs 2008 and 2009 exceeds the cumulative −1.5 percent prospective documentation and coding adjustment that has already been applied to the national capital Federal rate by 3.9 percentage points (5.4 percent minus 1.5 percent). An additional cumulative adjustment of −3.9 percent to the national capital Federal rate would be necessary to eliminate the full effect of the documentation and coding changes due to the adoption of the MS–DRGs on future payments. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

4. Proposed Prospective MS–DRG Documentation and Coding Adjustment to the National Capital Federal Rate for FY 2011 and Subsequent Years

We continue to believe that it is appropriate to make adjustments to the capital IPPS rates to eliminate the effect of any documentation and coding changes as a result of the implementation of the MS–DRGs. These adjustments are intended to ensure that future annual aggregate IPPS payments are the same as payments that otherwise would have been made had the prospective adjustments for documentation and coding applied in FY 2008 and FY 2009 accurately reflected the change due to documentation and coding that occurred in those years. As noted in section V.A. of this preamble, under section 1886(g) of the Act, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs (that is, the capital IPPS). We have

consistently stated since the initial implementation of the MS–DRG system that we do not believe it is appropriate for Medicare expenditures under the capital IPPS to increase due to MS–DRG related changes in documentation and coding. Accordingly, we believe that it is appropriate under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, to make adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs. We believe that this is appropriate because, in absence of such adjustments, the effect of the documentation and coding changes resulting from the adoption of the MS–DRGs results in inappropriately high capital IPPS payments because that portion of the increase in aggregate payments is not due to an increase in patient severity of illness (and costs).

As discussed in greater detail in section II.D.7. of this preamble, we explain that we are proposing a −2.9 percent adjustment for FY 2011 under the authority of section 7(b)(1)(B) of Public Law 110–90. We refer readers to that section of the preamble for a detailed discussion of the issue. In section II.D.6. of this preamble, we also discuss our retrospective evaluation of the FY 2009 claims, and our actuaries' determination that implementation of the MS–DRG system resulted in a 5.4 percent change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. The estimated 5.4 percent cumulative documentation and coding effect for FYs 2008 and 2009 exceeds the cumulative −1.5 percent prospective documentation and coding adjustment that has already been applied to the national capital Federal rate. Thus, an additional cumulative adjustment of −3.9 percent would be necessary to meet the requirements of section 7(b)(1)(A) of Public Law 110–90 to make an appropriate prospective adjustment to the IPPS operating average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments. However, we are not proposing a prospective adjustment to the IPPS operating average standardized amounts under section 7(b)(1)(A) of Public Law 110–90 for FY 2011.

As discussed above in this section, given the increase in payments that we have determined is due to documentation and coding, we believe it is necessary and appropriate under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, to make further adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, consistently with transitional policies we have adopted in many similar cases and in order to maintain consistency as far as possible with the adjustments that we are proposing to apply to IPPS hospitals, we are proposing an adjustment of −2.9 percent in FY 2011 to the national capital Federal rate. We believe that this proposed adjustment allows us to moderate the effects to hospitals in one year and to maintain equity between hospitals paid on the basis of different prospective rates. We are seeking public comment on the proposed −2.9 percent prospective adjustment to the national capital Federal rate for FY 2011 and our plans to address in future rulemaking cycles the cumulative effect of changes in case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009, noting that our current estimates of the remaining adjustment to the national capital Federal rate is −1.0 percent. We intend to update our analysis with FY 2009 data on claim paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

Therefore, in this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing to reduce the capital Federal rate in FY 2011 by −2.9 percent to account for the cumulative effect of the estimated changes in documentation and coding changes under the MS–DRG system in FYs 2008 and 2009 that did not reflect real changes in case-mix. Furthermore, consistent with our proposal for the hospital-specific rates under the operating IPPS, we are proposing to leave that proposed −2.9 percent adjustment in place for subsequent fiscal years to account for the effect in FY 2011 and subsequent years. As noted above, we intend to address in future rulemaking cycles the remaining estimated adjustment to the national capital Federal rate of −1.0 percent (that is, the estimated cumulative effect of documentation and coding changes under the MS–DRG system for FYs 2008 and 2009 of −5.4 percent minus the existing −0.6 percent and −0.9 adjustments and the proposed FY 2011 of −2.9 percent adjustment).

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

Under § 412.74, Puerto Rico hospitals are currently paid based on 75 percent of the national capital Federal rate and 25 percent of the Puerto Rico-specific capital rate. In the FY 2009 IPPS final rule (73 FR 48775), consistent with our development of the FY 2009 Puerto Rico-specific operating standardized amount, we did not apply the additional −0.9 percent documentation and coding adjustment (or the cumulative −1.5 percent adjustment) to the FY 2009 Puerto Rico-specific capital rate. However, the statute gives broad authority to the Secretary under section 1886(g) of the Act, with respect to the development of and adjustments to a capital PPS, and therefore we would not be outside the authority of section 1886(g) of the Act in applying the documentation and coding adjustment to the Puerto Rico-specific portion of the capital payment rate. To date, we had not applied a documentation and coding adjustment to the Puerto Rico-specific capital rate because we have historically made changes to the capital IPPS consistent with those changes made to the operating IPPS. We stated that we may propose to apply such an adjustment to the Puerto Rico capital rates in the future.

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43928), when we performed a retrospective evaluation of the FY 2008 claims data of hospitals located in Puerto Rico using the same methodology discussed above, we found that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 from hospitals located in Puerto Rico was approximately 1.3 percent. Given this case-mix increase due to changes in documentation and coding under the MS–DRGs, we had proposed to adjust the Puerto Rico-specific capital rate by −1.3 percent in FY 2010 for the FY 2008 increase in case-mix due to changes in documentation and coding under the MS–DRGs. However, in that same final rule, postponed the adoption of any documentation and coding adjustments to the capital IPPS rates until a full analysis of FY 2009 case-mix changes could be completed. We indicated that any future documentation and coding adjustment to the capital

Puerto Rico-specific IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data for Puerto Rico hospitals would be established through the notice and comment rulemaking process.

As discussed in section II.D.9. of this preamble, when we performed a retrospective evaluation of the FY 2009 claims data of hospitals located in Puerto Rico using the same methodology discussed above, we found that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 from hospitals located in Puerto Rico was approximately 2.4 percent. Given this case-mix increase due to changes in documentation and coding under the MS–DRGs, consistent with our proposal to adjust the FY 2011 capital Federal rate presented above and consistent with our proposed adjustment to the FY 2011 Puerto Rico-specific standardized amount discussed in section II.D.9. of the preamble of this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, we are proposing to adjust the Puerto Rico-specific capital rate by −2.4 percent in FY 2011 for the cumulative increase in case-mix due to changes in documentation and coding under the MS–DRGs for FYs 2008 and 2009. In addition, consistent with our other proposals concerning prospective MS–DRG documentation and coding adjustments to the capital Federal rate and operating IPPS standardized amounts presented in this proposed rule, we are proposing to leave that proposed −2.4 percent adjustment in place for subsequent fiscal years in order to ensure that changes in documentation and coding resulting from the adoption of the MS–DRGs do not lead to an increase in aggregate payments not reflective of an increase in real case-mix. We are proposing that the proposed −2.4 percent documentation and coding adjustment would be applied to the capital Puerto Rico-specific rate that accounts for 25 percent of payments to hospitals located in Puerto Rico, with the remaining 75 percent based on the proposed national capital Federal rate, which we are proposing to adjust for documentation and coding as described above. Consequently, the proposed overall reduction to the FY 2011 payment rates for hospitals located in Puerto Rico to account for documentation and coding changes would be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national capital Federal rate. As noted above, the Puerto Rico-specific capital rate was not adjusted for the cumulative effects of documentation and coding changes in FY 2008 or FY 2009 as is the case with the national capital Federal rate.

F. Other Proposed Changes for FY 2011

The proposed annual update to the capital IPPS national and Puerto Rico-specific rates, as provided for at § 412.308(c), for FY 2011 is discussed in section III. of the Addendum to this proposed rule.

VI. Proposed Changes for Hospitals Excluded From the IPPS

A. Excluded Hospitals

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. A per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. The updated target amount was multiplied by total Medicare discharges during that period and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers, which included rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals.

Payment to children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

For FY 2011, we are proposing that the rate-of-increase percentage to be applied to the target amount for cancer and children's hospitals and RNHCIs would be the proposed FY 2011 percentage increase in the IPPS operating market basket. Beginning with FY 2006, we have used the percentage increase in the IPPS operating market basket to update the target amounts for children's and cancer hospitals. As explained in the FY 2006 IPPS final rule (70 FR 47396 through 47398), with IRFs, IPFs, and LTCHs being paid under their own PPS, the remaining number of providers being paid based on reasonable cost subject to a ceiling (that is, children's and cancer hospitals and RNHCIs) is too small and the cost report data are too limited to be able to create a market basket solely for these hospitals. We are proposing to continue to use the IPPS market basket to update the target amounts for children's and cancer hospitals and RNHCIs for the reasons discussed in the FY 2006 IPPS final rule.

We are proposing to use the revised and rebased FY 2006-based IPPS operating market baskets to update the target amounts for children's and cancer hospitals and RNHCIs for FY 2011. Based on IHS Global Insight, Inc.'s 2010 first quarter forecast, with historical data through the 2009 fourth quarter, we are estimating that the FY 2011 update to the IPPS operating market basket would be 2.4 percent (that is, the current estimate of the market basket rate-of-increase).

We calculated the proposed rate-of-increase in the IPPS operating market basket for FY 2011 using the most recent data available. However, if data that are more recent become available for the final rule, we will use them to calculate the IPPS operating market basket update for FY 2011. Therefore, consistent with our proposal that the rate-of-increase percentage for cancer and children's hospitals and RNHCIs would be the proposed percentage increase in the FY 2011 IPPS operating market basket, the proposed FY 2011 rate-of-increase percentage that would be applied to FY 2010 target amounts in order to calculate the FY 2011 target amounts for cancer and children's hospitals and RNHCIs would be 2.4 percent, in accordance with the applicable regulations in 42 CFR 413.40.

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

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We

refer readers to section IV. of the Addendum to this proposed rule for the specific proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2011. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

B. Critical Access Hospitals (CAHs)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs) under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and that meet the CAH conditions of participation under 42 CFR part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR part 413.

2. CAH Optional Method Election for Payment of Outpatient Services

Section 1834(g) of the Act establishes the payment rules for outpatient services furnished by a CAH. Section 403(d) of Public Law 106–113 (BBRA) amended section 1834(g) of the Act to provide for two methods of payment for outpatient services furnished by a CAH. Specifically, section 1834(g)(1) of the Act, as amended by Public Law 106–113, provided that the amount of payment for outpatient services furnished by a CAH is equal to the reasonable cost of providing such services, unless the CAH made an election, under section 1834(g)(2) of the Act, to receive amounts that were equal to the reasonable cost of the CAH for facility services plus, with respect to the professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. The election made under section 1834(g)(2) of the Act is sometimes referred to as "method II." Throughout this section of this preamble, we refer to this election as the "optional method." Section 202 of Public Law 106–554 (BIPA) amended section 1834(g)(2)(B) of the Act to increase the payment for professional services under the optional method to 115 percent of the amount otherwise paid for professional services under Medicare. In addition, section 405(a)(1) of Public Law 108–173 (MMA) amended section 1834(g)(l) of the Act by inserting the phrase "equal to 101 percent of" before the phrase "the reasonable costs." However, the MMA made no changes to the amount of payment under the optional method at section 1834(g)(2)(A) of the Act. As stated earlier, the proposed policies and payment rates in this proposed rule do not reflect the provisions of the recently enacted Public Law 111–148, as amended by Public Law 111–152. We plan to address the provisions of Public Law 111–148, as amended, as they affect payments to CAHs in separate documents in the **Federal Register** or through further instructions.

Accordingly, section 1834(g) of the Act currently provides for two methods of payment for outpatient CAH services. Under the method specified at section 1834(g)(1) of the Act, facility services are paid at 101 percent of reasonable costs to the CAH through the Medicare fiscal intermediary or the Medicare Part A/B MAC, while payments for physician and other professional services are made to the physician or other practitioner under the Medicare Physician Fee Schedule (MPFS) through the Medicare carriers. Under section 1834(g)(2) of the Act (the optional method), a CAH submits bills for both the facility and the professional services to its Medicare fiscal intermediary or its Medicare Part A/B MAC. If a CAH chooses this optional method for outpatient services, the physician or other practitioner must reassign his or her billing rights to the CAH to bill the Medicare program for those services. In accordance with section 1834(g)(2) of the Act, under this optional method, the CAH receives reasonable cost payment for its facility costs and, with respect to the professional services, 115 percent of the amount otherwise paid for professional services under Medicare.

The existing regulations at § 413.70(b)(3)(i)(A) require that if a CAH wishes to elect the optional method, that election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. The regulations at § 413.70(b)(3)(i)(B) specify that once an election is made for a cost reporting period, that election remains in effect for all of that period. Therefore, under the existing regulations, a CAH that is being paid under the optional method is required to submit an election on an annual basis if it wishes to continue to be paid under the optional method for a subsequent cost reporting period.

We have been informed that, in past years, some CAHs have submitted their elections several days late, which has caused these CAHs to lose their optional method election for the entire cost reporting year and has resulted in financial hardship for these providers. Such untimely submission of the optional method election may be due to staffing turnovers at the CAH as well as a change in fiscal intermediary or MAC assignments because, in the past, some CAHs received correspondence from their fiscal intermediaries or MACs reminding them to elect the optional method on an annual basis. Due to the significant consequences if a CAH fails to make a timely election, we are proposing to amend the regulations at § 413.70(b)(3)(i) to state that, effective for CAH cost reporting periods beginning on or after October 1, 2010, if a CAH has elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010 or chooses to elect the optional method for its upcoming cost reporting period, that election will remain in place until it is terminated.

We believe that removing the annual election requirement will reduce any perceived burden associated with the election process and make it easier for CAHs to maintain their election if they experience administrative staffing changes. If a CAH is being paid under the traditional method and wishes to elect the optional method, it must submit its election in writing to its servicing fiscal intermediary or MAC at least 30 days prior to the first cost reporting period for which the election is effective. Once that initial election is made, it will remain in place until it is terminated.

We are proposing to revise the regulations to include a mechanism for CAHs that are being paid under the optional method to terminate that election. Specifically, we are proposing that if a CAH is being paid under the optional method and wishes to terminate that election, it must submit its termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. Because the proposed effective date for this provision is for cost reporting periods beginning on or after October 1, 2010, CAHs that have cost reporting periods beginning in October 2010 or November 2010 may not have sufficient time to terminate their optional method election at least 30 days prior to the start of the cost reporting period. Therefore, we are proposing that CAHs that have cost reporting periods beginning in October 2010 or November 2010 and elected the optional method in 2009 that wish to terminate that election will have until December 1, 2010, to terminate their prior year election. The termination will be effective for the entire FY 2011 cost reporting period. Thus, if a CAH with a cost reporting period beginning in

October 2010 or November 2010 terminates its optional method election after the beginning of its cost reporting period but before December 1, 2010, the fiscal intermediary or MAC would be instructed to reprocess any payments made under the optional method for services provided during that period as efficiently as possible.

Section 1834(g)(2)(B) of the Act provides that if a CAH elects the optional method, it is not required that each physician or other practitioner providing professional services in the CAH must reassign billing rights with respect to the services. Rather, the reassignment of billing rights is physician/practitioner specific. For this reason, the optional payment method should not apply to the computation of payments to the CAH for its facility services in conjunction with services furnished by physicians and practitioners who have not reassigned such billing rights. Accordingly, if a physician or practitioner has not reassigned his or her billing rights to the CAH, the CAH will be paid for its facility services at 101 percent of reasonable cost, as specified at § 413.70(b)(2)(i) of the regulations. If a CAH experiences changes in its physician or practitioner staffing, there may be a change in which physicians or practitioners choose to reassign their billing rights in order to permit the CAH to bill for their professional services. In order to ensure appropriate payments, and specifically, in order to ensure that there is no duplicate billing for a physician's or practitioner's professional services by the CAH to the fiscal intermediary or MAC and by the physician or practitioner providing the service to the carrier, a CAH must continue to notify its fiscal intermediary or MAC when changes in reassignment occur.

In summary, we are proposing to revise § 413.70(b)(3)(i) to specify, under paragraphs (A)(*1*) and (A)(*2*), that for CAH cost reporting periods beginning on or after October 1, 2010, once a CAH elects the optional method, including an election made for its most recent cost reporting period beginning prior to October 1, 2010, its election will remain in place until it is terminated. That is, CAHs would no longer be required to make an annual election in order to continue to be paid under the optional method in a subsequent year. If a CAH has not elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010, and would like to be paid for outpatient services under the optional method for a cost reporting period beginning on or after October 1, 2010, consistent with our existing regulations, it would be required to provide its election in writing to its servicing fiscal intermediary or MAC at least 30 days prior to the start of the first cost reporting period for which the election is effective. In addition, we are proposing to revise the regulations to specify that if a CAH wishes to terminate its optional method election, it must submit its termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. We are proposing that CAHs that have cost reporting periods beginning in October 2010 or November 2010 and elected the optional method in 2009, that wish to terminate that election, will have until December 1, 2010, to terminate their prior year election. The termination would be effective for the entire FY 2011 cost reporting period. We also are proposing to make a conforming change to paragraph (b)(3)(i)(D).

3. Costs of Provider Taxes as Allowable Costs for CAHs

a. Background and Statutory Basis

Currently, certain taxes assessed against a provider may be allowable costs under Medicare to the extent that such taxes are related to the reasonable and necessary cost of providing patient care and represent costs actually incurred. Reasonable cost reimbursement is addressed in section 1861(v)(1)(A) of the Act. Section 1861(v)(1)(A) of the Act defines "reasonable cost," in part, as the cost actually incurred, excluding costs found to be unnecessary in the efficient delivery of needed health services and are determined in accordance with regulations establishing the method or methods to be used and the items to be included. Section 1861(v)(1)(A) of the Act does not specifically address the determination of reasonable costs, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs.

We have issued regulations implementing this provision of the Act, including 42 CFR 413.9(a) which provide that the determination of reasonable cost "must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." In addition, § 413.9(c) requires that the provision for payment of reasonable cost of services is intended to meet the actual costs incurred in providing services. Therefore, in accordance with the statute, the regulations include two principles that help guide the determination of which expenses may be considered allowable reasonable costs that can be paid under Medicare; that is, such costs must be "related" to the care of Medicare beneficiaries, and such costs must actually be "incurred."

Consistent with these provisions, we also have issued policy instructions in the Provider Reimbursement Manual (PRM) for determining allowable reasonable costs under Medicare. Specifically, section 2122 of the PRM sets forth Medicare policy on determining when taxes levied on providers are allowable costs and provides a list of taxes that are considered unallowable costs. Specifically, section 2122.1 (General Rule) of the PRM states: "The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expenses should not include fines and penalties." Section 2122.2 (Taxes Not Allowable as Costs) of the PRM lists certain taxes that are levied on providers that are not allowable costs. The listed taxes are:

- Federal income and excess profit taxes, including any interest or penalties paid thereon (A).
- State or local income and excess profit taxes (B).
- Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense. (C)
- Taxes from which exemptions are available to the provider. (D)
- Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives. (E)
- Taxes on property which is not used in the rendition of covered services. (F)
- Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider. (G)
- Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc. (H)

b. Proposed Clarification of Payment Policy for Provider Taxes

We have learned that there is some confusion relating to the determination of whether a tax is an allowable cost. We believe that much of this confusion

has arisen because it may be possible to read sections 2122.1 and 2122.2 of the PRM as permitting all taxes assessed on a provider by a State that are not specifically listed in section 2122.2 to be treated as allowable costs. Section 2122 of the PRM was last updated in 1979 when States typically raised revenue only from income, sales, and property taxes. The list in section 2212.2 is incomplete now, as it does not reflect the variety of provider taxes imposed by States. In addition, we are concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. For example, in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals.

We believe that the treatment of these types of payments on the Medicare cost report should be analogous to the adjustments described at § 413.98 of the regulations. Specifically, § 413.98(d) provides that the "true cost of the goods or services is the net amount actually paid for them." Section 413.98 specifically addresses the purchase of goods and services and reflects the statutory mandate that a provider's allowable costs are the net expenses it incurs for items and services. In situations in which payments that are associated with the assessed tax are made to providers specifically to make the provider whole or partly whole for the tax expenses, Medicare should similarly recognize only the net expense incurred by the provider. Thus, while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as a reasonable cost the net tax expense; that is, the tax paid by the provider, reduced by payments the provider *received* that are associated with the assessed tax. In addition, we do not believe that determinations made regarding whether the structure of specific taxes and subsequent reimbursements are consistent with Medicaid "hold harmless" provisions necessarily require the Medicare program to find that the same tax is an allowable cost. The Medicare statute and regulations set forth a different standard that requires a determination of how much of the allowable tax expense is actually "incurred" by the provider.

In this proposed rule, we are proposing to clarify our policy concerning when provider taxes may be considered allowable costs under Medicare. As stated above, section 2122 of the PRM was last updated in 1979, and it no longer reflects the variety of provider taxes that may be imposed by States. Although some of the more recently enacted provider taxes may be allowable costs, we are concerned that some of these taxes may not be "related to the care of beneficiaries" and that some, if not all, of the costs of these taxes might not be actually "incurred" by the providers. This payment policy may not directly affect providers that are paid under a Medicare prospective payment system unless a cost-based prospective payment system is rebased on more current reported reasonable costs. However, this policy clarification could impact certain providers that are paid on the basis of their incurred reasonable costs, such as CAHs.

Therefore, we are proposing to clarify the policy set forth in sections 2122.1 and 2122.2 of the PRM to reflect our concerns set forth above regarding when certain provider taxes may be allowable costs under the Medicare program. We will modify the PRM consistent with these principles. We believe that the proposed revision would clarify that our Medicare contractors will determine the allowability of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is proper to account for payments providers receive that are associated with the assessed tax.

VII. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2011

A. Background of the LTCH PPS

1. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provides for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals that are described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days." Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: Specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (LOS) (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Section 123 of the BBRA requires the PPS for LTCHs to be a "per discharge" system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs.

Section 307(b)(1) of the BIPA, among other things, mandates that the Secretary shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In the August 30, 2002 **Federal Register**, we issued a final rule that implemented the LTCH PPS authorized under the BBRA and BIPA (67 FR 55954). This system currently uses information from LTCH patient records to classify patients into distinct MS-long-term care diagnosis-related groups (MS–LTC–DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each MS–LTC–DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA reasonable cost-based payment provisions are located at 42 CFR Part 413.) With the implementation of the

PPS for acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. (Generally, in section VIII. of this preamble, when we refer to discharges, the intent is to describe Medicare discharges.) The August 30, 2002 final rule further details the payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we provided for a 5-year transition period. During this 5-year transition period, a LTCH's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

In addition, in the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, Subpart O also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

In the June 6, 2003 **Federal Register**, we published a final rule that set forth the FY 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs (68 FR 34122). It also changed the annual period for which the payment rates were to be effective, such that the annual updated rates were effective from July 1 through June 30 instead of from October 1 through September 30. We referred to the July through June time period as a "long-term care hospital rate year" (LTCH PPS rate year). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate are based on a LTCH PPS rate year. In the past, while the LTCH payment rate updates were effective July 1, the annual update of the DRG classifications and relative weights for LTCHs continued to be linked to the annual adjustments of the acute care hospital inpatient DRGs and were effective each October 1.

As discussed in detail in section VIII.A.1. of the May 9, 2008 RY 2009 LTCH PPS final rule (73 FR 26788), we again changed the schedule for the annual updates of the LTCH PPS Federal payment rates beginning with RY 2010. We consolidated the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates and description of the methodology and data used to calculate these payment rates with the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights now occur on the same schedule and appear in the same publication. As a result, the updates to the rates and the weights are now effective on October 1 (on a Federal fiscal year schedule), and the annual updates to the LTCH PPS Federal rates are no longer published with a July 1 effective date (73 FR 26797 through 26798).

Public Law 110–173 (MMSEA), enacted on December 29, 2007, included provisions that have various effects on the LTCH PPS. In addition to amending section 1861 of the Act to add a subsection (ccc) which provided an additional definition of LTCHs, Public Law 110–173 also required the Secretary to submit, no later than 18 months after the date of enactment of the law, a report to Congress on a study of national long-term care hospital facility and patient criteria that included "recommendations for such legislation and administrative actions, including timelines for the implementation of LTCH patient criteria or other actions, as the Secretary determines appropriate." The payment policy provisions under sections 114(c)(1) and 114(c)(2) of Public Law 110–173 focused on providing 3 years of relief for certain LTCHs from the percentage threshold payment adjustment policy at 42 CFR 412.534 and 412.536. However, because of the original implementation schedule of those sections of the regulations, the payment provisions had varying timeframes of applicability (73 FR 29701 through 29704). In addition, section 114(c)(3) of Public Law 110–173 provided that the Secretary shall not apply, for the 3-year period beginning on the date of enactment of the Act the revision to the short-stay outlier (SSO) policy that was finalized in the RY 2008 LTCH PPS final rule (72 FR 26904 and 26992). In addition, section 114(c)(4) of Public Law 110–173 provided that the Secretary shall not, for the 3-year period beginning on the date of enactment of the Act, make the one-time adjustment to the payment rates provided for in § 412.523(d)(3) or any similar provision (73 FR 26800 through 26804). The statute also provided that the base rate for RY 2008 be the same as the base rate for RY 2007 (the revised base rate, however, does not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008) (73 FR 24875 through 24877). Section 114(d) of Public Law 110–173 established a 3-year moratorium (with specified exceptions) on the establishment and classification of new LTCHs, LTCH satellites, and on the increase in the number of LTCH beds in existing LTCHs or satellite facilities. Finally, section 114(f) of Public Law 110–173 provided for an expanded review of medical necessity for admission and continued stay at LTCHs.

In the RY 2009 LTCH PPS final rule (73 FR 26804 through 26812), we established the applicable Federal rates for RY 2009, consistent with section 1886(m)(2) of the Act as amended by Public Law 110–173. We also revised the regulations at § 412.523(d)(3) to change the methodology for the one-time budget neutrality adjustment and to comply with section 114(c)(4) of Public Law 110–173. Other policy revisions that were necessary as a result of the statutory changes of Public Law 110–173 were addressed in separate interim final rules with comment period (73 FR 24871 and 73 FR 29699). In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43976 through 43990), we address all of the public comments received and finalized these two interim final rules with comment period.

Section 4302 of the ARRA, Public Law 111–5, enacted on February 17, 2009, included several amendments to the provisions set forth in section 114 of Public Law 110–173. Specifically, section 4302(a) modified the effective dates of the provisions of section 114(c) of Public Law 110–173, described above, and added an additional category of LTCHs or satellite facilities that would not be subject to the percentage threshold payment adjustment at § 412.536 for a 3-year period. In

addition, section 4302(a)(2)(A) of Public Law 111–5 added "grandfathered" satellites (specified in § 412.22(h)(3)(i) of the regulations) to those "applicable" LTCHs (specified in § 412.534(g) of the regulations) originally granted relief under section 114(c) of Public Law 110–173. We issued instructions to the fiscal intermediaries and MACs interpreting the provisions of section 4302 of Public Law 111–5 (Change Request 6444). In addition, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (43990 through 43992), we implemented the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period. We received one piece of timely correspondence regarding the provisions of section 4302 of Public Law 111–5 that were implemented through the interim final rule with comment period that was included in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. We plan to address this public comment and finalize the interim final rule with comment period in the FY 2011 IPPS/LTCH PPS final rule, which is scheduled to be issued by August l, 2010.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

2. Criteria for Classification as a LTCH

a. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) of greater than 25 days. Alternatively, § 412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

b. Hospitals Excluded from the LTCH PPS

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and therefore, are not subject to the LTCH PPS rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) (42 U.S.C. 1395b–1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

3. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, if the Medicare payment to the LTCH is the full LTC–DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a). However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the SSO threshold is exceeded. Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC–DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

4. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services "for which a claim is submitted other than in an electronic form specified by the Secretary." Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial "in such unusual cases as the Secretary finds appropriate" (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified at 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic healthcare transactions according to the applicable transactions and code sets standards.

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

1. Background

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

DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data."

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the "long-term care diagnosis-related groups (LTC–DRGs). Although the patient classification systems used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect "the differences in patient resource use * * *" of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113)).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development and implementation and rationale for the use of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification system unless specifically referring to the previous LTC–DRG patient classification system that was in effect before October 1, 2007.) We believe the MS–DRGs (and by extension, the MS–LTC–DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS–DRGs adopted in FY 2008 represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In FY 2009, an additional MS–DRG was adopted for a total of 746 distinct groupings (73 FR 48497). For FY 2011, we are proposing to delete one MS–DRG and create two new MS–DRGs, for a net gain of one MS–DRG, as noted in section II. of the preamble of this proposed rule. This would result in 747 distinct MS–DRG groupings for FY 2011. Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, and as discussed in greater detail below in section VII.B.3.f. of this preamble, we use low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs with less than 25 LTCH cases) in determining the MS–LTC–DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. For purposes of determining the relative weights for the large number of low-volume MS–LTC–DRGs, we group all of the low-volume MS–LTC–DRGs into five quintiles based on average charge per discharge. (A detailed discussion of the initial development and application of the quintile methodology appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for short-stay outlier (SSO) cases (that is, cases where the covered LOS at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS–LTC–DRG). Furthermore, we make adjustments to account for nonmonotonically increasing weights, when necessary. That is, theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges such that, in the severity levels within a base MS–LTC–DRG, the weights should increase monotonically with severity from the lowest to highest severity level. (We discuss nonmonotonicity in greater detail and our methodology to adjust the RY 2010 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights in section VII.B.3.g. (Step 6) of this preamble.)

2. Patient Classifications Into MS–LTC–DRGs

a. Background

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the MS–DRGs used under the IPPS.

The MS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKG), or minor surgical procedures (for example, biopsy of skin and subcutaneous tissue (procedure code 86.11)) do not affect the MS–LTC–DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Additional or secondary diagnoses;
- Surgical procedures;
- Age;
- Sex; and
- Discharge status of the patient.

Through FY 2010, the number of secondary or additional diagnoses and the number of surgical procedures considered for MS–DRG assignment was limited to eight and six, respectively. Elsewhere in this proposed rule, however, we are proposing that, for claims submitted on the 5010 format beginning January 1, 2011, we would increase the capacity to process diagnosis and procedure codes up to 25 diagnoses and 25 procedures. This will include one principal diagnosis and up to 24 secondary diagnoses for severity of illness determinations. We refer readers to section II.G.11.c. of this preamble for a complete discussion of this proposed change.

Upon the discharge of the patient from a LTCH, the LTCH must assign

appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM,* a product of the American Hospital Association. (We refer readers to section II.G.11. of this preamble for additional information on the annual revisions to the ICD–9–CM codes.)

With respect to the ICD–9–CM coding system, we have been discussing the conversion to the ICD–10–CM and the ICD–10–PCS coding systems for many years. As is discussed in detail in section II.G.11. of this preamble, the ICD–10 coding systems applicable to hospital inpatient services will be implemented on October 1, 2013. In order for the industry to make the necessary conversions from ICD–9–CM to ICD–10–CM and ICD–10–PCS, we proposed, through the ICD–9–CM Coordination and Maintenance Committee, to consider a moratorium on updates to the ICD–9–CM and ICD–10 coding sets. We refer readers to section II.G.11. of this preamble for additional information on the adoption of ICD–10–CM and ICD–10–PCS.

To create the MS–DRGs (and by extension, the MS–LTC–DRGs), individual DRGs were subdivided according to the presence of specific secondary diagnoses designated as complications or comorbidities (CCs) into three, two, or one level, depending on the impact of the CCs on resources used for those cases. Specifically, there are sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or a major complication and comorbidity (MCC). We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a detailed discussion about the creation of MS–DRGs based on severity of illness levels (72 FR 47141 through 47175).

Medicare contractors (that is, fiscal intermediaries and MACs) enter the clinical and demographic information submitted by LTCHs into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, certain cases are selected for further development (74 FR 43949).

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). The GROUPER software used under the LTCH PPS is the same GROUPER software program used under the IPPS. Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for LTCHs to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as provided in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the MS–LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG and MS–LTC–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

b. Proposed Changes to the MS–LTC–DRGs for FY 2011

As specified by our regulations at § 412.517(a), which requires that the LTC–MS–DRG classifications and relative weights be updated annually and consistent with our historical practice of using the same patient classification system under the LTCH PPS as is used under the IPPS, in this proposed rule, we are proposing to modify and revise the MS–LTC–DRG classifications effective October 1, 2010, through September 30, 2011 (FY 2011) consistent with the proposed changes to specific MS–DRG classifications presented above in section II.G. of this proposed rule (that is, proposed GROUPER Version 28.0). Therefore, the MS–LTC–DRGs for FY 2011 presented in this proposed rule are the same as the proposed MS–DRGs that would be used under the IPPS for FY 2011. In addition, because the proposed MS–LTC–DRGs for FY 2011 are the same as the proposed MS–DRGs for FY 2011, the other changes that would affect MS–DRG (and by extension MS–LTC–DRG) assignments under Version 28.0 of the GROUPER discussed in section II.G. of the preamble of this proposed rule, including the proposed changes to the MCE software and proposed changes to the ICD–9–CM coding system, would also be applicable under the LTCH PPS for FY 2011.

3. Development of the Proposed FY 2011 MS–LTC–DRG Relative Weights

a. General Overview of the Development of the MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55984), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case.

Although the adoption of the MS–LTC–DRGs resulted in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity (as discussed in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and the FY 2009 IPPS final rule (73 FR 48542 through 48550)), the basic methodology for developing the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule continues to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to

account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Development of the Proposed MS–LTC–DRG Relative Weights for FY 2011

Beginning with the FY 2008 update, we established a budget neutral requirement for the annual update to the MS–LTC–DRG classifications and relative weights at 42 CFR 412.517(b) (in conjunction with § 412.503), such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the classification and relative weight changes (May 11, 2007 LTCH PPS final rule, 72 FR 26882 through 26884).

Consistent with § 412.517(b), we apply a two-step budget neutrality methodology, which is based on the current year MS–LTC–DRG classifications and relative weights. (For additional information on the established two-step budget neutrality methodology, we refer readers to the FY 2008 IPPS final rule (72 FR 47295 through 47296).) Thus, the proposed annual update to the MS–LTC–DRG classifications and relative weights for FY 2011 is based on the FY 2010 MS–LTC–DRG classifications and relative weights.

c. Data

In this proposed rule, to calculate the proposed MS–LTC–DRG relative weights for FY 2011, we are proposing to obtain total Medicare allowable charges from FY 2009 Medicare LTCH bill data from the December 2009 update of the MedPAR file, which are the best available data at this time, and to use the proposed Version 28.0 of the GROUPER to classify LTCH cases (as discussed above). We also are proposing that if more recent data become available, we would use those data and the finalized Version 28.0 of the GROUPER in establishing the FY 2011 MS–LTC–DRG relative weights in the final rule.

Consistent with our historical methodology, we excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 or section 222(a) of Public Law 92–603. In addition, as is the case with the IPPS, Medicare Advantage (Part C) claims are now included in the MedPAR files (74 FR 43808). Consistent with IPPS policy, we are proposing to exclude such claims in the calculations for the relative weights under the LTCH PPS that are used to determine payments for fee-for-service Medicare claims. Specifically, we have added an edit to the relative weight calculation to remove any claims from the MedPAR files that have a GHO Paid indicator value of "1," which effectively removes Medicare Advantage claims from the relative weight calculations (73 FR 48532). Accordingly, in the development of the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, we excluded the data of 13 all-inclusive rate providers and the 2 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2009 MedPAR file, as well as any Medicare Advantage claims.

d. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonrandom distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, consistent with the methodology we have used since the implementation of the LTCH PPS, we are proposing to continue to use a hospital-specific relative value (HSRV) methodology to calculate the proposed MS–LTC–DRG relative weights. We believe this method removes this hospital-specific source of bias in measuring LTCH average charges (67 FR 55985). Specifically, we are reducing the impact of the variation in charges across providers on any particular proposed MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

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

In accordance with our established methodology, we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for SSOs under § 412.529 as described in section VII.B.3.g. (step 3) of the preamble of this proposed rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case. (67 FR 55989)

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

e. Treatment of Severity Levels in Developing the Proposed MS–LTC–DRG Relative Weights

For purposes of determining the proposed MS–LTC–DRG relative weights, there are three different categories of DRGs based on volume of cases within specific MS–LTC–DRGs. MS–LTC–DRGs with at least 25 cases are each assigned a unique proposed relative weight; low-volume proposed MS–LTC–DRGs (that is, proposed MS–LTC–DRGs that contain between 1 and 24 cases based on a given year's claims data) are grouped into quintiles (as described below) and assigned the proposed relative weight of the quintile. No-volume proposed MS–LTC–DRGs (that is, no cases in the given year's claims data were assigned to those proposed MS–LTC–DRGs) are crosswalked to other proposed MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG (as described in greater detail below). (We provide in-depth discussions of our policy regarding weight-setting for low-volume MS–LTC–DRGs in section VII.B.3.f. of the preamble of this proposed rule and for no-volume MS–LTC–DRGs, under Step 5 in section VII.B.3.g. of the preamble of this proposed rule.)

As also noted above, while the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG relative weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. In general, consistent with our existing methodology, we are proposing to determine the proposed FY 2011 relative weights for the proposed MS–LTC–DRGs using the following steps: (1) If a proposed MS–LTC–DRG has at least 25 cases, it is assigned its own proposed relative weight; (2) if a proposed MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we compute a proposed relative weight for all of the proposed MS–LTC–DRGs assigned to that quintile; and (3) if a proposed MS–LTC–DRG has no cases, it is crosswalked to another proposed MS–LTC–DRG based upon clinical similarities to assign an appropriate proposed relative weight (as described below in detail in Step 5 of section VII.B.3.g. of this preamble). Furthermore, in determining the proposed FY 2011 MS–LTC–DRG relative weights, when necessary, we are proposing to make adjustments to account for nonmonotonicity, as discussed in greater detail below in Step 6 of section VII.B.3.g. of this preamble. We refer readers to the discussion in the FY 2010 IPPS/RY LTCH PPS final rule for our rationale for including an adjustment for nonmonotonicity (74 FR 43953 through 43954).

f. Low-Volume MS–LTC–DRGs

In order to account for proposed MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with our existing methodology, for purposes of determining the MS–LTC–DRG relative weights, we are proposing to continue to employ this quintile methodology for low-volume proposed MS–LTC–DRGs, such that we group those "low-volume MS–LTC–DRGs" (that is, MS–LTC–DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges (67 FR 55984 through 55995 and 72 FR 47283 through 47288). In determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, in cases where the initial assignment of a low-volume proposed MS–LTC–DRG to quintiles results in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we are proposing to make adjustments to the treatment of low-volume proposed MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VII.B.3.g. (Step 6) in this preamble.

In this proposed rule, using LTCH cases from the December 2009 update of the FY 2009 MedPAR file, we identified 283 MS–LTC–DRGs that contained between 1 and 24 cases. This list of proposed MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 56 proposed MS–LTC–DRGs (283/5 = 56 with 3 proposed MS–LTC–DRG as the remainder). We are proposing to assign a low-volume proposed MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume proposed MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Furthermore, because the number of proposed MS–LTC–DRGs with less than 25 cases was not evenly divisible by 5, the average charge of the low-volume quintile was used to determine which of the low-volume quintiles would contain the 3 additional low-volume proposed MS–LTC–DRGs. Specifically, after sorting the 283 low-volume proposed MS–LTC–DRGs by ascending order by average charge, we are proposing to assign the first fifth (1st through 56th) of low-volume proposed MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The proposed MS–LTC–DRGs with the highest average charge cases would be assigned into Quintile 5. Because the average charge of the 113th low-volume proposed MS–LTC–DRG in the sorted list is closer to the average charge of the 112th low-volume proposed MS–LTC–DRG (assigned to Quintile 2) than to the average charge of the 114th low-volume MS–LTC–DRG (assigned to Quintile 3), we are proposing to place it into Quintile 2 (such that Quintile 2 would contain 57 low-volume proposed MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This process was repeated through the remaining low-volume proposed MS–LTC–DRGs so that 2 of the 5 low-volume quintiles contain 56 MS–LTC–DRGs (Quintiles 1 and 4) and the other 3 low-volume quintiles contain 57 MS–LTC–DRGs (Quintiles 2, 3, and 5).

Accordingly, in order to determine the proposed FY 2011 relative weights for the proposed MS–LTC–DRGs with low volume, we are proposing to use the 5 low-volume quintiles described above. The composition of each of the 5 low-volume quintiles shown in the chart below was used in determining the proposed FY 2011 MS–LTC–DRG relative weights (as shown in Table 11 of the Addendum to this proposed rule). We determined a proposed relative weight and (geometric) average length of stay for each of the 5 low-volume quintiles using the methodology that we applied to the proposed MS–LTC–DRGs (25 or more cases), as described in section VII.B.3.g. of the preamble of this proposed rule. We are proposing to assign the same proposed relative weight and average length of stay to each of the low-volume proposed MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the proposed relative weights based on our methodology.

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Proposed Composition of Low-Volume Quintiles for FY 2011*

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
Quintile 1	
26	Craniotomy & endovascular intracranial procedures w CC
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC
81	Nontraumatic stupor & coma w/o MCC
84	Traumatic stupor & coma, coma >1 hr w/o CC/MCC
87	Traumatic stupor & coma, coma <1 hr w/o CC/MCC
93	Other disorders of nervous system w/o CC/MCC
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC
122	Acute major eye infections w/o CC/MCC
148	Ear, nose, mouth & throat malignancy w/o CC/MCC
149	Dysequilibrium
151	Epistaxis w/o MCC
188	Pleural effusion w/o CC/MCC
198	Interstitial lung disease w/o CC/MCC
201	Pneumothorax w/o CC/MCC
244	Permanent cardiac pacemaker implant w/o CC/MCC
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC
354	Hernia procedures except inguinal & femoral w CC
376	Digestive malignancy w/o CC/MCC
379	G.I. hemorrhage w/o CC/MCC
383	Uncomplicated peptic ulcer w MCC
387	Inflammatory bowel disease w/o CC/MCC
390	G.I. obstruction w/o CC/MCC
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC
440	Disorders of pancreas except malignancy w/o CC/MCC
491	Back & neck procedures except spinal fusion w/o CC/MCC
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC
547	Connective tissue disorders w/o CC/MCC
553	Bone diseases & arthropathies w MCC
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
601	Non-malignant breast disorders w/o CC/MCC
645	Endocrine disorders w/o CC/MCC
656	Kidney & ureter procedures for neoplasm w MCC
694	Urinary stones w/ot esw lithotripsy w/o MCC
696	Kidney & urinary tract signs & symptoms w/o MCC
730	Other male reproductive system diagnoses w/o CC/MCC
759	Infections, female reproductive system w/o CC/MCC
781	Other antepartum diagnoses w medical complications
821	Lymphoma & leukemia w major O.R. procedure w CC
824	Lymphoma & non-acute leukemia w other O.R. proc w CC
842	Lymphoma & non-acute leukemia w/o CC/MCC
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC
864	Fever of unknown origin
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC
882	Neuroses except depressive
887	Other mental disorder diagnoses
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
915	Allergic reactions w MCC
918	Poisoning & toxic effects of drugs w/o MCC
923	Other injury, poisoning & toxic effect diag w/o MCC
965	Other multiple significant trauma w/o CC/MCC
976	HIV w major related condition w/o CC/MCC
Quintile 2	
59	Multiple sclerosis & cerebellar ataxia w CC
83	Traumatic stupor & coma, coma >1 hr w CC
98	Non-bacterial infect of nervous sys exc viral meningitis w CC
121	Acute major eye infections w CC/MCC
158	Dental & Oral Diseases w CC
159	Dental & Oral Diseases w/o CC/MCC
182	Respiratory neoplasms w/o CC/MCC
200	Pneumothorax w CC
203	Bronchitis & asthma w/o CC/MCC
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC
236	Coronary bypass w/o cardiac cath w/o MCC
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC
254	Other vascular procedures w/o CC/MCC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC
284	Circulatory disorders w AMI, expired w CC
305	Hypertension w/o MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
369	Major esophageal disorders w CC
384	Uncomplicated peptic ulcer w/o MCC
395	Other digestive system diagnoses w/o CC/MCC
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC
433	Cirrhosis & alcoholic hepatitis w CC
436	Malignancy of hepatobiliary system or pancreas w CC
446	Disorders of the biliary tract w/o CC/MCC
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC
487	Knee procedures w pdx of infection w/o CC/MCC
502	Soft tissue procedures w/o CC/MCC
536	Fractures of hip & pelvis w/o MCC
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
554	Bone diseases & arthropathies w/o MCC
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
598	Malignant breast disorders w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
625	Thyroid, parathyroid & thyroglossal procedures w MCC
643	Endocrine disorders w MCC
644	Endocrine disorders w CC
669	Transurethral procedures w CC
687	Kidney & urinary tract neoplasms w CC
700	Other kidney & urinary tract diagnoses w/o CC/MCC
710	Penis procedures w/o CC/MCC
723	Malignancy, male reproductive system w CC
755	Malignancy, female reproductive system w CC
760	Menstrual & other female reproductive system disorders w CC/MCC
776	Postpartum & post abortion diagnoses w/o O.R. procedure
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC
815	Reticuloendothelial & immunity disorders w CC
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC
880	Acute adjustment reaction & psychosocial dysfunction
883	Disorders of personality & impulse control
903	Wound debridements for injuries w/o CC/MCC
906	Hand procedures for injuries
909	Other O.R. procedures for injuries w/o CC/MCC
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC
957	Other O.R. procedures for multiple significant trauma w MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC
Quintile 3	
29	Spinal procedures w CC
75	Viral meningitis w CC/MCC
77	Hypertensive encephalopathy w MCC
78	Hypertensive encephalopathy w CC
82	Traumatic stupor & coma, coma >1 hr w MCC
90	Concussion w/o CC/MCC
96	Bacterial & tuberculous infections of nervous system w/o CC/MCC
102	Headaches w MCC
124	Other disorders of the eye w MCC
156	Nasal trauma & deformity w/o CC/MCC
243	Permanent cardiac pacemaker implant w CC
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC
258	Cardiac pacemaker device replacement w MCC
287	Circulatory disorders except AMI, w card cath w/o MCC
311	Angina pectoris
313	Chest pain
327	Stomach, esophageal & duodenal proc w CC
328	Stomach, esophageal & duodenal proc w/o CC/MCC
344	Minor small & large bowel procedures w MCC
348	Anal & stomal procedures w CC
370	Major esophageal disorders w/o CC/MCC
381	Complicated peptic ulcer w CC
382	Complicated peptic ulcer w/o CC/MCC
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC
467	Revision of hip or knee replacement w CC
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC
506	Major thumb or joint procedures
516	Other musculoskelet sys & conn tiss O.R. proc w CC
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
581	Other skin, subcut tiss & breast proc w/o CC/MCC
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC
659	Kidney & ureter procedures for non-neoplasm w MCC
671	Urethral procedures w CC/MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
675	Other kidney & urinary tract procedures w/o CC/MCC
686	Kidney & urinary tract neoplasms w MCC
693	Urinary stones w/o esw lithotripsy w MCC
695	Kidney & urinary tract signs & symptoms w MCC
697	Urethral stricture
713	Transurethral prostatectomy w CC/MCC
726	Benign prostatic hypertrophy w/o MCC
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC
834	Acute leukemia w/o major O.R. procedure w MCC
835	Acute leukemia w/o major O.R. procedure w CC
843	Other myeloprolif dis or poorly diff neopl diag w MCC
844	Other myeloprolif dis or poorly diff neopl diag w CC
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC
866	Viral illness w/o MCC
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
905	Skin grafts for injuries w/o CC/MCC
922	Other injury, poisoning & toxic effect diag w MCC
963	Other multiple significant trauma w MCC
970	HIV w extensive O.R. procedure w/o MCC
Quintile 4	
11	Tracheostomy for face,mouth & neck diagnoses w MCC
25	Craniotomy & endovascular intracranial procedures w MCC
28	Spinal procedures w MCC
31	Ventricular shunt procedures w MCC
37	Extracranial procedures w MCC
69	Transient ischemia
80	Nontraumatic stupor & coma w MCC
89	Concussion w CC
113	Orbital procedures w CC/MCC
125	Other disorders of the eye w/o MCC
157	Dental & Oral Diseases w MCC
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC
256	Upper limb & toe amputation for circ system disorders w CC
261	Cardiac pacemaker revision except device replacement w CC
336	Peritoneal adhesiolysis w CC
347	Anal & stomal procedures w MCC
353	Hernia procedures except inguinal & femoral w MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
358	Other digestive system O.R. procedures w/o CC/MCC
380	Complicated peptic ulcer w MCC
406	Pancreas, liver & shunt procedures w CC
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC
460	Spinal fusion except cervical w/o MCC
472	Cervical spinal fusion w CC
478	Biopsies of musculoskeletal system & connective tissue w CC
480	Hip & femur procedures except major joint w MCC
485	Knee procedures w pdx of infection w MCC
486	Knee procedures w pdx of infection w CC
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices
496	Local excision & removal int fix devices exc hip & femur w CC
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC
504	Foot procedures w CC
505	Foot procedures w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC
533	Fractures of femur w MCC
534	Fractures of femur w/o MCC
619	O.R. procedures for obesity w MCC
642	Inborn errors of metabolism
660	Kidney & ureter procedures for non-neoplasm w CC
663	Minor bladder procedures w CC
665	Prostatectomy w MCC
668	Transurethral procedures w MCC
685	Admit for renal dialysis
709	Penis procedures w CC/MCC
711	Testes procedures w CC/MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC
722	Malignancy, male reproductive system w MCC
746	Vagina, cervix & vulva procedures w CC/MCC
749	Other female reproductive system O.R. procedures w CC/MCC
754	Malignancy, female reproductive system w MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
917	Poisoning & toxic effects of drugs w MCC
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
964	Other multiple significant trauma w CC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
	Quintile 5
20	Intracranial vascular procedures w PDX hemorrhage w MCC
38	Extracranial procedures w CC
53	Spinal disorders & injuries w/o CC/MCC
58	Multiple sclerosis & cerebellar ataxia w MCC
72	Nonspecific cerebrovascular disorders w/o CC/MCC
131	Cranial/facial procedures w CC/MCC
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC
164	Major chest procedures w CC
168	Other resp system O.R. procedures w/o CC/MCC
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
237	Major cardiovascular procedures w MCC
242	Permanent cardiac pacemaker implant w MCC
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC
260	Cardiac pacemaker revision except device replacement w MCC
263	Vein ligation & stripping
286	Circulatory disorders except AMI, w card cath w MCC
294	Deep vein thrombophlebitis w CC/MCC
304	Hypertension w MCC
326	Stomach, esophageal & duodenal proc w MCC
330	Major small & large bowel procedures w CC
335	Peritoneal adhesiolysis w MCC
345	Minor small & large bowel procedures w CC
350	Inguinal & femoral hernia procedures w MCC
405	Pancreas, liver & shunt procedures w MCC
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC
411	Cholecystectomy w c.d.e. w MCC
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC
418	Laparoscopic cholecystectomy w/o c.d.e. w CC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC
459	Spinal fusion except cervical w MCC
466	Revision of hip or knee replacement w MCC
469	Major joint replacement or reattachment of lower extremity w MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC
481	Hip & femur procedures except major joint w CC
482	Hip & femur procedures except major joint w/o CC/MCC
492	Lower extrem & humer proc except hip,foot,femur w MCC
493	Lower extrem & humer proc except hip,foot,femur w CC
498	Local excision & removal int fix devices of hip & femur w CC/MCC
507	Major shoulder or elbow joint procedures w CC/MCC
509	Arthroscopy
597	Malignant breast disorders w MCC
653	Major bladder procedures w MCC
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC
725	Benign prostatic hypertrophy w MCC
761	Menstrual & other female reproductive system disorders w/o CC/MCC
769	Postpartum & post abortion diagnoses w O.R. procedure
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC
876	O.R. procedure w principal diagnoses of mental illness
969	HIV w extensive O.R. procedure w MCC
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC

* Initial composition of proposed low-volume quintiles prior to adjusting for nonmonotonicity (as discussed in step 6 in section VII.B.3.g. of this preamble). Any adjustments to the proposed low volume quintile assignments to address nonmonotonicity are identified in Table 11 of the Addendum of this proposed rule.

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We note that we will continue to monitor the volume (that is, the number of LTCH cases) in the low-volume quintiles to ensure that our quintile assignments used in determining the proposed MS–LTC–DRG relative weights result in appropriate payment for such cases and do not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

g. Steps for Determining the Proposed FY 2011 MS–LTC–DRG Relative Weights

In general, we are proposing to determine the FY 2011 MS–LTC–DRG relative weights based on our existing methodology. For additional information on the original development of this methodology, and modifications to it since the adoption of the MS–LTC–DRGs, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55995) and the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43951 through 43966).

In summary, for FY 2011, to determine the proposed FY 2011 MS–LTC–DRG relative weights, we are proposing to group LTCH cases to the appropriate proposed MS–LTC–DRG, while taking into account the low-volume proposed MS–LTC–DRGs (as described above). After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculate the proposed FY 2011 relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less (as discussed in greater detail below). Next, we adjust the number of cases in each proposed MS–LTC–DRG (or low-volume quintile) for the effect of SSO cases (step 3 below). After removing statistical outliers (step 1 below) and cases with a length of stay of less than 8 days (step 2 below), the SSO adjusted discharges and corresponding charges are then used to calculate "relative adjusted weights" for each proposed MS–LTC–DRG (or low-volume quintile) using the HSRV method.

Below we discuss in detail the steps for calculating the proposed FY 2011 MS–LTC–DRG relative weights. We note that, as we stated in section VII.B.3.c. of this preamble, we excluded the data of all-inclusive rate LTCHs, LTCHs that are paid in accordance with demonstration projects, and any Medicare Advantage claims in the FY 2009 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2011 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we are proposing to continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate

relative weight that does not truly reflect relative resource use among the MS–LTC–DRGs. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 2—Remove cases with a length of stay of 7 days or less.

The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2011 MS–LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the proposed FY 2011 MS–LTC–DRG relative weights, we are proposing to remove LTCH cases with a length of stay of 7 days or less. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 3—Adjust charges for the effects of SSOs.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. As the next step in the calculation of the proposed FY 2011 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we are proposing to adjust each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503).

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

Counting SSO cases as full discharges with no adjustment in determining the proposed RY 2011 MS–LTC–DRG relative weights would lower the proposed FY 2011 MS–LTC–DRG relative weight for affected MS–LTC–DRGs because the relatively lower charges of the SSO cases would bring down the average charge for all cases within an MS–LTC–DRG. This would result in an "underpayment" for non-SSO cases and an "overpayment" for SSO cases. Therefore, we are proposing to adjust for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 4—Calculate the proposed FY 2011 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we are proposing to calculate the proposed FY 2011 MS–LTC–DRG relative weights using the HSRV methodology, which is an iterative process. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the SSO adjusted charge per discharge (see Step 3) of the LTCH case (after removing the statistical outliers (see Step 1)) and LTCH cases with a length of stay of 7 days or less (see Step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed MS–LTC–DRG, the proposed FY 2011 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) is calculated by dividing the sum of all the LTCH's proposed MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above is multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Determine a proposed FY 2011 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, we are proposing to determine the proposed FY 2011 relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the December 2009 update of the FY 2009 MedPAR file for this proposed rule). Using these data, we identified a number of proposed MS–LTC–DRGs for which there were no LTCH cases in the database, such that no patients who would have been classified to those proposed MS–LTC–DRGs were treated in LTCHs during FY 2009 and, therefore, no charge data were available for these proposed MS–LTC–DRGs. Thus, in the process of determining the proposed MS–LTC–DRG relative weights, we were unable to calculate proposed relative weights for the proposed MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these proposed MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we are proposing to assign a proposed relative weight to each of the no-volume proposed MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of "transplant" proposed MS–LTC–DRGs and "error" proposed MS–LTC–DRGs, as discussed below). (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55991 and 74 FR 43959 through 43960.)

In general, we determined proposed FY 2011 relative weights for the proposed MS–LTC–DRGs with no LTCH cases in the FY 2009 MedPAR file used in this proposed rule (that is, "no-volume" proposed MS–LTC–DRGs) by crosswalking each no-volume proposed MS–LTC–DRG to another proposed MS–LTC–DRG with a calculated proposed relative weight (determined in accordance with the methodology described above). Then, the "no-volume" proposed MS–LTC–DRG is assigned the same proposed relative weight (and average length of stay) of the proposed MS–LTC–DRG to which it was crosswalked (as described in greater detail below).

Of the 747 proposed MS–LTC–DRGs for FY 2011, we identified 223 proposed MS–LTC–DRGs for which there were no LTCH cases in the database (including

the 8 "transplant" proposed MS–LTC–DRGs and 2 "error" proposed MS–LTC–DRGs). As stated above, we are proposing to assign proposed relative weights for each of the 213 no-volume proposed MS–LTC–DRGs (with the exception of the 8 "transplant" proposed MS–LTC–DRGs and the 2 "error" proposed MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 524 (747—223 = 524) proposed MS–LTC–DRGs for which we were able to determine proposed relative weights based on FY 2009 LTCH claims data using the steps described above. (For the remainder of this discussion, we refer to the proposed "crosswalked" MS–LTC–DRGs as the proposed MS–LTC–DRGs to which we are proposing to crosswalk one of the 213 "no volume" proposed MS–LTC–DRGs for purposes of determining a proposed relative weight.) Then, we are proposing to assign the no-volume proposed MS–LTC–DRG the proposed relative weight of the proposed crosswalked MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

In this proposed rule, we are proposing to use the following methodology for determining the proposed FY 2011 relative weights for the no-volume proposed MS–LTC–DRGs: We crosswalk the no-volume proposed MS–LTC–DRG to a proposed MS–LTC–DRG for which there were LTCH cases in the FY 2009 MedPAR file and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We evaluate the relative costliness in determining the applicable proposed MS–LTC–DRG to which a no-volume proposed MS–LTC–DRG was crosswalked in order to assign an appropriate proposed relative weight for the no-volume MS–LTC–DRGs in FY 2011. (For more detail on our process for evaluating relative costliness, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (73 FR 48543).) We believe in the rare event that there would be a few LTCH cases grouped to one of the no-volume proposed MS–LTC–DRGs in FY 2011, the proposed relative weights assigned based on the crosswalked proposed MS–LTC–DRGs would result in an appropriate LTCH PPS payment because the proposed crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use.

We then assign the proposed relative weight of the crosswalked proposed MS–LTC–DRG as the proposed relative weight for the no-volume proposed MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) would have the same proposed relative weight for FY 2011. We note that if the crosswalked proposed MS–LTC–DRG had 25 cases or more, its proposed relative weight, which is calculated using the methodology described in Steps 1 through 4 above, is assigned to the no-volume proposed MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume proposed MS–LTC–DRG is crosswalked has 24 or less cases and, therefore, is designated to one of the low-volume quintiles for purposes of determining the proposed relative weights, we assign the proposed relative weight of the applicable low-volume quintile to the no-volume proposed MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) have the same proposed relative weight for FY 2011. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume proposed MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing proposed relative weights.)

For this proposed rule, a list of the no-volume MS–LTC–DRGs and the proposed MS–LTC–DRG to which it is crosswalked (that is, the crosswalked MS–LTC–DRG) for FY 2011 is shown in the chart below.

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Proposed No-Volume MS-LTC-DRG Crosswalk for FY 2011

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
12	Tracheostomy for face,mouth & neck diagnoses w CC	147
13	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	148
14	Allogeneic bone marrow transplant	812
15	Autologous bone marrow transplant	812
21	Intracranial vascular procedures w PDX hemorrhage w CC	65
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	66
23	Craniotomy w major device implant or acute complex CNS PDX w MCC	25
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	26
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC	26
30	Spinal procedures w/o CC/MCC	29
32	Ventricular shunt procedures w CC	31
33	Ventricular shunt procedures w/o CC/MCC	31
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedurew CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
67	Nonspecific cva & precerebral occlusion w/o infarct w MCC	68
76	Viral meningitis w/o CC/MCC	75
79	Hypertensive encephalopathy w/o CC/MCC	305
88	Concussion w MCC	89
103	Headaches w/o MCC	149
114	Orbital procedures w/o CC/MCC	125
115	Extraocular procedures except orbit	125
116	Intraocular procedures w CC/MCC	124
117	Intraocular procedures w/o CC/MCC	125
123	Neurological eye disorders	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
132	Cranial/facial procedures w/o CC/MCC	156
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	148
135	Sinus & mastoid procedures w CC/MCC	133

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
136	Sinus & mastoid procedures w/o CC/MCC	148
137	Mouth procedures w CC/MCC	158
138	Mouth procedures w/o CC/MCC	159
139	Salivary gland procedures	159
150	Epistaxis w MCC	152
165	Major chest procedures w/o CC/MCC	168
183	Major chest trauma w MCC	163
184	Major chest trauma w CC	164
185	Major chest trauma w/o CC/MCC	168
215	Other heart assist system implant	254
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	253
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	254
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	254
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	254
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	254
235	Coronary bypass w/o cardiac cath w MCC	237
238	Major cardiovascular procedures w/o MCC	254
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	254
245	AICD generator procedures	244
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	252
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC	254
259	Cardiac pacemaker device replacement w/o MCC	262
265	AICD lead procedures	264
285	Circulatory disorders w AMI, expired w/o CC/MCC	284
295	Deep vein thrombophlebitis w/o CC/MCC	301
296	Cardiac arrest, unexplained w MCC	291

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
297	Cardiac arrest, unexplained w CC	292
298	Cardiac arrest, unexplained w/o CC/MCC	293
331	Major small & large bowel procedures w/o CC/MCC	358
332	Rectal resection w MCC	347
333	Rectal resection w CC	348
334	Rectal resection w/o CC/MCC	348
337	Peritoneal adhesiolysis w/o CC/MCC	336
338	Appendectomy w complicated principal diag w MCC	372
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
346	Minor small & large bowel procedures w/o CC/MCC	344
349	Anal & stomal procedures w/o CC/MCC	348
351	Inguinal & femoral hernia procedures w CC	354
352	Inguinal & femoral hernia procedures w/o CC/MCC	354
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
407	Pancreas, liver & shunt procedures w/o CC/MCC	419
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	419
412	Cholecystectomy w c.d.e. w CC	418
413	Cholecystectomy w c.d.e. w/o CC/MCC	419
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	417
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	418
420	Hepatobiliary diagnostic procedures w MCC	423
421	Hepatobiliary diagnostic procedures w CC	424
422	Hepatobiliary diagnostic procedures w/o CC/MCC	424
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	433
453	Combined anterior/posterior spinal fusion w MCC	459
454	Combined anterior/posterior spinal fusion w CC	459
455	Combined anterior/posterior spinal fusion w/o CC/MCC	460
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	459
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	460
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
468	Revision of hip or knee replacement w/o CC/MCC	467

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
471	Cervical spinal fusion w MCC	472
473	Cervical spinal fusion w/o CC/MCC	472
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
488	Knee procedures w/o pdx of infection w CC/MCC	485
489	Knee procedures w/o pdx of infection w/o CC/MCC	487
508	Major shoulder or elbow joint procedures w/o CC/MCC	517
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	515
511	Shoulder,elbow or forearm proc,exc major joint proc w CC	516
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	517
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	517
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	537
582	Mastectomy for malignancy w CC/MCC	597
583	Mastectomy for malignancy w/o CC/MCC	596
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	605
599	Malignant breast disorders w/o CC/MCC	601
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	617
620	O.R. procedures for obesity w CC	619
621	O.R. procedures for obesity w/o CC/MCC	619
626	Thyroid, parathyroid & thyroglossal procedures w CC	625
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	625
654	Major bladder procedures w CC	660
655	Major bladder procedures w/o CC/MCC	660
657	Kidney & ureter procedures forneoplasm w CC	656
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	656
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	660
662	Minor bladder procedures w MCC	663
664	Minor bladder procedures w/o CC/MCC	663
666	Prostatectomy w CC	665
667	Prostatectomy w/o CC/MCC	665
670	Transurethral procedures w/o CC/MCC	669
672	Urethral procedures w/o CC/MCC	671
688	Kidney & urinary tract neoplasms w/o CC/MCC	687
691	Urinary stones w esw lithotripsy w CC/MCC	693
692	Urinary stones w esw lithotripsy w/o CC/MCC	694

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
707	Major male pelvic procedures w CC/MCC	659
708	Major male pelvic procedures w/o CC/MCC	660
712	Testes procedures w/o CC/MCC	711
714	Transurethral prostatectomy w/o CC/MCC	669
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	717
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	718
724	Malignancy, male reproductive system w/o CC/MCC	723
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	749
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	749
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	749
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	755
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	628
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	629
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	630
742	Uterine & adnexa proc for non-malignancy w CC/MCC	629
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	630
744	D&C, conization, laparascopy & tubal interruption w CC/MCC	749
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	749
747	Vagina, cervix & vulva procedures w/o CC/MCC	749
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
756	Malignancy, female reproductive system w/o CC/MCC	755
765	Cesarean section w CC/MCC	749
766	Cesarean section w/o CC/MCC	749
767	Vaginal delivery w sterilization &/or D&C	749
768	Vaginal delivery w O.R. proc except steril &/or D&C	749
770	Abortion w D&C, aspiration curettage or hysterotomy	749
774	Vaginal delivery w complicating diagnoses	749
775	Vaginal delivery w/o complicating diagnoses	749
777	Ectopic pregnancy	776
778	Threatened abortion	776
779	Abortion w/o D&C	776
780	False labor	776
782	Other antepartum diagnoses w/o medical complications	781
789	Neonates, died or transferred to another acute care facility	781

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
790	Extreme immaturity or respiratory distress syndrome, neonate	781
791	Prematurity w major problems	781
792	Prematurity w/o major problems	781
793	Full term neonate w major problems	781
794	Neonate w other significant problems	781
795	Normal newborn	781
799	Splenectomy w MCC	802
800	Splenectomy w CC	802
801	Splenectomy w/o CC/MCC	802
803	Other O.R. proc of the blood & blood forming organs w CC	802
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	802
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	812
816	Reticuloendothelial & immunity disorders w/o CC/MCC	815
820	Lymphoma & leukemia w major O.R. procedure w MCC	821
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	821
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	824
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	827
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	827
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	846
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	847
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	847
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	847
894	Alcohol/drug abuse or dependence, left ama	897
895	Alcohol/drug abuse or dependence w rehabilitation therapy	897
916	Allergic reactions w/o MCC	915
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	928
955	Craniotomy for multiple significant trauma	25
956	Limb reattachment, hip & femur proc for multiple significant trauma	480
958	Other O.R. procedures for multiple significant trauma w CC	957
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	957
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	985

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To illustrate this methodology for determining the proposed relative weights for the proposed FY 2011 MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume proposed MS–LTC–DRGs crosswalk information for FY 2011 provided in the chart above.

Example: There were no cases in the FY 2009 MedPAR file used for this proposed rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that proposed MS–LTC–DRG 70 (Nonspecific Cebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same proposed relative weight of MS–LTC–DRG 70 of 0.9204 for FY 2011 to MS–LTC–DRG 61 (Table 11 of the Addendum to this proposed rule).

Furthermore, for FY 2011, consistent with our historical relative weight methodology, we are proposing to establish MS–LTC–DRG relative weights of 0.0000 for the following transplant proposed MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (proposed MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (proposed MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (proposed MS–LTC–DRG 5); Liver Transplant without MCC (proposed MS–LTC–DRG 6); Lung Transplant (proposed MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (proposed MS–LTC–DRG 8); Pancreas Transplant (proposed MS–LTC–DRG 10); and Kidney Transplant (proposed MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. At the present time, we only include these eight transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these MS–LTC–DRGs would be administratively burdensome. (For additional information regarding our treatment of transplant MS–LTC–DRGs, we refer readers to the RY 2010 LTCH PPS final rule (74 FR 43964).) Again, we note that, as this system is dynamic, it is entirely possible that the number of MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no-volume MS–LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Step 6—Adjust the proposed FY 2011 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed earlier in this section, the MS–DRGs contain base DRGs that have been subdivided into one, two, or three severity of illness levels. Where there are three severity levels, the most severe level has at least one code that is referred to as an MCC (that is, major complication or comorbidity). The next lower severity level contains cases with at least one code that is a CC (that is, complication or comorbidity). Those cases without an MCC or a CC are referred to as "without CC/MCC." When data do not support the creation of three severity levels, the base DRG is subdivided into either two levels or the base DRG is not subdivided. The two-level subdivisions could consist of the with CC/MCC and the without CC/MCC. Alternatively, the other type of two-level subdivision may consist of the MCC and without MCC.

In those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the "without CC/MCC" MS–LTC–DRG are expected to have a lower resource use (and lower costs) than the "with CC/MCC" MS–LTC–DRG (in the case of a two-level split) or both the "with CC" and the "with MCC" MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights decrease as severity decreased (that is, if within a base MS–LTC–DRG, an MS–LTC–DRG with CC has a higher relative weight than one with MCC, or the MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others), they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because the payment for the cases in the higher severity level in a base MS–LTC–DRG (which are generally expected to have higher resource use and costs) would be lower than the payment for cases in a lower severity level within the same base MS–LTC–DRG (which are generally expected to have lower resource use and costs). Consequently, in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, consistent with our historical methodology, we are proposing to combine MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. For a comprehensive description of our existing methodology to adjust for nonmonotonicity, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43964 through 43966). Any adjustments for nonmonotonicity that were made in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule by applying this methodology are denoted in Table 11 of the Addendum to this proposed rule.

Step 7— Calculate the proposed FY 2011 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary to develop the LTCH PPS under section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the MS–LTC–DRG classifications and relative weights is done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes (§ 412.517(b) in conjunction with § 412.503). (For a detailed discussion on the establishment of the budget neutrality requirement to update the MS–LTC–DRG classifications and relative weights, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26881).)

The MS–LTC–DRG classifications and relative weights are updated annually based on the most recent available LTCH claims data to reflect changes in relative LTCH resource use (§ 412.517(a) in accordance with § 412.503). Under the budget neutrality requirement at § 412.517(b), for each annual update, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, we are proposing to update the proposed MS–LTC–DRG classifications and relative weights for FY 2011 based on the most recent available LTCH data, and to apply a budget neutrality adjustment in determining the proposed FY 2011 MS–LTC–DRG relative weights.

To ensure budget neutrality in the proposed update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), we are proposing to continue to use our established two-step budget neutrality methodology. Specifically, in the first step of our MS–LTC–DRG budget neutrality methodology, we calculate and apply a normalization factor to the proposed recalibrated relative weights (the result of Steps 1 through 6 above) to ensure that estimated payments are not influenced by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the proposed MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases the average CMI.

To calculate the proposed normalization factor for FY 2011 (the first step of our budget neutrality methodology), we are proposing to use

the following three steps: (1.a.) We use the most recent available LTCH claims data (FY 2009) and group them using the proposed FY 2011 GROUPER (Version 28.0) and the proposed recalibrated FY 2011 MS–LTC–DRG relative weights (determined in steps 1 through 6 of the Steps for Determining the Proposed FY 2011 MS–LTC–DRG Relative Weights above) to calculate the average CMI; (1.b.) we group the same LTCH claims data (FY 2009) using the FY 2010 GROUPER (Version 27.0) and FY 2010 MS–LTC–DRG relative weights and calculate the average CMI; and (1.c.) we compute the ratio of these average CMIs by dividing the average CMI for FY 2010 (determined in Step 1.b.) by the average CMI for FY 2011 (determined in step 1.a.). In determining the proposed MS–LTC–DRG relative weights for FY 2011, each recalibrated MS–LTC–DRG relative weight is multiplied by 1.10362 in the first step of the budget neutrality methodology, which produces "normalized relative weights."

In the second step of our MS–LTC–DRG budget neutrality methodology, we determine a budget neutrality factor to ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (that is, the proposed FY 2011 MS–LTC–DRG classifications and relative weights) are equal to estimated aggregate LTCH PPS payments before reclassification and recalibration (that is, the FY 2010 MS–LTC–DRG classifications and relative weights). Accordingly, consistent with our existing methodology, we are proposing to use FY 2009 discharge data to simulate payments and compare estimated aggregate LTCH PPS payments using the FY 2010 MS–LTC–DRGs and relative weights to estimate aggregate LTCH PPS payments using the proposed FY 2011 MS–LTC–DRGs and relative weights. As noted above, the most recent available LTCH claims data for this proposed rule are from the December 2009 update of the FY 2009 MedPAR file. Consistent with our historical policy of using the best available data, we are proposing to use the most recently available claims data for determining the budget neutrality adjustment factor in the final rule.

For this proposed rule, we determined the proposed FY 2011 budget neutrality adjustment factor rule using the following three steps: (2.a.) we simulate estimated total LTCH PPS payments using the normalized proposed relative weights for FY 2011 and GROUPER Version 28.0 (as described above); (2.b.) we simulate estimated total LTCH PPS payments using the FY 2010 GROUPER (Version 27.0) and the FY 2010 MS–LTC–DRG relative weights shown in Table 11 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44183 through 44192); and (2.c.) we calculate the ratio of these estimated total LTCH PPS payments by dividing the estimated total LTCH PPS payments using the FY 2010 GROUPER (Version 27.0) and the FY 2010 MS–LTC–DRG relative weights (determined in step 2.b.) by the estimated total LTCH PPS payments using the proposed FY 2011 GROUPER (Version 28.0) and the normalized proposed MS–LTC–DRG relative weights for FY 2011 (determined in Step 2.a.). In determining the proposed FY 2011 MS–LTC–DRG relative weights, each normalized proposed relative weight is multiplied by a budget neutrality factor of 0.987575 in the second step of the budget neutrality methodology to determine the proposed budget neutral FY 2011 relative weight for each MS–LTC–DRG.

Accordingly, in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, consistent with our existing methodology, we are proposing to apply a normalization factor of 1.10362 and a budget neutrality factor of 0.987575 (computed as described above).

Table 11 in the Addendum to this proposed rule lists the proposed MS–LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining SSO payments under § 412.529) for FY 2011. The proposed FY 2011 MS–LTC–DRG relative weights in Table 11 in the Addendum to this proposed rule reflect both the proposed normalization factor of 1.10362 and the proposed budget neutrality factor of 0.987575.

C. Proposed Changes to the LTCH Payment Rates and Other Changes to the FY 2011 LTCH PPS

1. Overview of Development of the LTCH Payment Rates

The LTCH PPS was effective beginning with a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective beginning with that cost reporting period, LTCHs were paid, during a 5-year transition period, a total LTCH prospective payment that was comprised of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion based on reasonable cost-based principles, unless the hospital made a one-time election to receive payment based on 100 percent of the Federal rate, as specified in § 412.533. New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth at § 412.515 through § 412.536. In this section, we discuss the factors that would be used to update the LTCH PPS standard Federal rate for the FY 2011 that would be effective for LTCH discharges occurring on or after October 1, 2010 through September 30, 2011.

For further details on the development of the FY 2003 standard Federal rate, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate, we refer readers to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), RY 2006 LTCH PPS final rule (70 FR 24179 through 24180), RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), RY 2009 LTCH PPS final rule (73 FR 26800 through 26804), and RY 2010 LTCH PPS final rule (74 FR 44021 through 44030). The proposed update to the LTCH PPS standard Federal rate for FY 2011 is presented in section V.A. of the Addendum to this proposed rule. The two components of the proposed update to the LTCH PPS standard Federal rate for FY 2011 are discussed below.

2. Market Basket for LTCHs Reimbursed Under the LTCH PPS

a. Overview

Historically, the Medicare program has used a market basket to account for price increases in the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. With the initial implementation of the LTCH PPS for FY 2003, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket (67 FR 56016 through 56017). The development of the initial LTCH PPS standard Federal rate for FY 2003, using the excluded hospital with capital market basket, is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033). For further details on the development of the excluded hospital with capital market basket, we refer readers to the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

Beginning in RY 2007, we adopted the rehabilitation, psychiatric, long-term care (RPL) hospital market basket based on FY 2002 data as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. As discussed in the RY 2007 LTCH PPS final rule (71 FR 27810), based on our research, we did not develop a market basket specific to LTCH services. We were unable to create a separate market basket specifically for LTCHs at that time due to the small number of facilities and the limited amount of data that was reported.

For further details on the development of the FY 2002-based RPL market basket, we refer readers to the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817).

b. Market Basket Under the LTCH PPS for FY 2011

When we initially created the FY 2002-based RPL market basket, we were unable to create a separate market basket specifically for LTCHs due, in part, to the small number of facilities and the limited data that were provided in the Medicare cost reports. Over the last several years, however, the number of LTCH facilities submitting valid Medicare cost report data has increased. Based on this development, as well as our desire to move from one RPL market basket to three stand-alone and provider-specific market baskets (for IRFs, IPFs, and LTCHs, respectively), we plan to begin exploring the viability of creating these market baskets for future use. However, as we discussed in the RY 2010 LTCH PPS final rule (74 FR 43967 through 43968), we are conducting further research to assist us in understanding the reasons for the variations in costs and cost structure between freestanding IRFs and hospital-based IRFs. We also are researching the reasons for similar variations in costs and cost structure between freestanding IPFs and hospital-based IPFs. Therefore, as we continue to explore the development of stand-alone market baskets for LTCHs, IRFs and IPFs, respectively, we believe that it is appropriate to continue to use the FY 2002-based RPL market basket for LTCHs, IRFs and IPFs under their respective PPSs.

In addition, for the reasons discussed when we adopted the RPL market basket for use under the LTCH PPS in the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817), we continue to believe that the RPL market basket appropriately reflect the cost structure of LTCHs. For the reasons explained above, in this proposed rule, we are proposing to continue to use the FY 2002-based RPL market basket under the LTCH PPS for FY 2011. We are hopeful that progress can be made in the near future with respect to creating stand-alone market baskets for LTCHs, IRFs, and IPFs and, as a result, may propose to rebase the appropriate market basket(s) for subsequent updates in the future.

c. Proposed Market Basket Update for LTCHs for FY 2011

Consistent with our historical practice, we estimate the RPL market basket update based on IHS Global Insight, Inc.'s forecast using the most recent available data. IHS Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the hospital market baskets. Based on IHS Global Insight Inc.'s first quarter 2010 forecast, the proposed FY 2011 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket is 2.4 percent. Consistent with our historical practice of using market basket estimates based on the most recent available data, we are proposing that if more recent data are available when we develop the final rule, we would use such data, if appropriate. (We note that in section V. of the Addendum to this proposed rule, for FY 2011, we are proposing to update the LTCH PPS standard Federal rate by -0.1 percent. This proposed update reflects an adjustment based on the most recent market basket estimate (currently 2.4 percent, as discussed above) and a proposed adjustment to account for the increase in case-mix in the prior periods (FYs 2008 through 2009) that resulted from changes in documentation and coding practices rather than increases in patients' severity of illness.)

d. Proposed Labor-Related Share Under the LTCH PPS for FY 2011

As discussed in section V.B. of the Addendum to this proposed rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS payments to account for differences in LTCH area wage levels at § 412.525(c). The labor-related portion of the LTCH PPS Federal rate, hereafter referred to as the labor-related share, is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index.

The labor-related share is determined by identifying the national average proportion of operating and capital costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Consistent with our proposal to continue to use the FY 2002-based RPL market basket under the LTCH PPS for FY 2011 discussed above, we are proposing to continue to define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, labor-intensive services, and a labor-related portion of capital based on the FY 2002-based RPL market basket. (Additional information on the development of the FY 2002-based RPL market basket used under the LTCH PPS can be found in the RY 2007 LTCH PPS final rule (71 FR 27809 through 27818).)

Furthermore, for FY 2011, we are proposing to continue to define the LTCH PPS labor-related share as the national average proportion of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs based on the FY 2002-based RPL market basket. Consistent with our historical practice of using the best available data, we are proposing to use IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the proposed labor-related share for the LTCH PPS for FY 2011 that would be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data.

The proposed labor-related share for FY 2011 would be the sum of the proposed FY 2011 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and FY 2011. The sum of the proposed relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) would be 71.537 percent, as shown in the chart below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent. Because the relative importance for capital in FY 2011 would be 8.414 percent of the FY 2002-based RPL market basket, we are proposing to take 46 percent of 8.414 percent to determine the proposed labor-related share of capital for FY 2011. The result would be 3.870 percent, which we are proposing to add to 71.537 percent for the operating cost amount to determine the total proposed

labor-related share for FY 2011. Thus, the labor-related share that we are proposing to use for LTCH PPS in FY 2011 would be 75.407 percent.

The chart below shows the proposed FY 2011 relative importance labor-related share using the FY 2002-based RPL market basket.

PROPOSED FY 2011 LABOR-RELATED SHARE BASED ON THE FY 2002–BASED RPL MARKET BASKET

Cost category	FY 2011 relative importance (percent)
Wages and Salaries	52.590
Employee Benefits	13.987
Professional Fees	2.848
All Other Labor-Intensive Services	2.112
Subtotal	71.537
Labor-Related Share of Capital Costs (46 percent × 8.414)	3.870
Total Labor-Related Share	75.407

Accordingly, under the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing to establish a labor-related share of 75.407 percent under the LTCH PPS for the FY 2011. Furthermore, consistent with our historical practice of using the best data available, we also are proposing that if more recent data are available to determine the labor-related share used under the LTCH PPS for FY 2011, we would use these data for determining the FY 2011 LTCH PPS labor-related share in the final rule.

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

a. Background

Beginning in RY 2007, in updating the standard Federal rate for the LTCH PPS, we have accounted for increases in payments from a past period that were due to changes in case-mix due to changes in documentation and coding practices. For additional information on the adjustments established for changes in LTCHs' case-mix due to changes in documentation and coding practices that occurred in a prior period, we refer readers to the following final rules published in the **Federal Register:** The RY 2007 LTCH PPS final rule (71 FR 27820); the RY 2008 LTCH PPS final rule (72 FR 26880 through 26890); the RY 2009 LTCH PPS final rule (73 FR 26805 through 26812); and the FY 2010IPPS/RY 2010 LTCH PPS final rule (74 FR 43969 through 43970).

For RY 2010, we performed an analysis of LTCHs' case-mix index (CMI) changes in the prior periods (FY 2007 and FY 2008) and established a methodology to determine if an adjustment to account for changes in documentation and coding practices was applicable (74 FR 43969 through 43970). This methodology is consistent with the methodology established for case-mix analysis under the IPPS. In general, under our established methodology, in order to isolate the documentation and coding effect, we divided the combined effect of the changes in documentation and coding and measurement by the measurement effect (74 FR 43970).

For the RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2007 and FY 2008 data for LTCH claims paid through December 2008. Based on this evaluation, our actuaries determined that case-mix increased 0.5 percent in FY 2007 and 1.3 percent in FY 2008 due to documentation and coding that did not reflect real changes in case-mix. In light of this analysis, in the RY 2010 LTCH PPS proposed rule, we proposed to apply a cumulative adjustment for changes in documentation and coding that do not reflect an increase in patients' severity of illness of −1.8 percent (that is, −0.5 percent for FY 2007 plus −1.3 percent for FY 2008). We also invited public comment on our proposed methodology and analysis. (For additional information on our methodology and the results of the retrospective evaluation, we refer reader to sections VIII.C.3. of the preamble of the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules (74 FR 24229 through 24230 and 74 FR 43970 through 43972, respectively).)

In the FY 2010 IPPS/LTCH PPS final rule, we responded to comments on our methodology for the retrospective evaluation of FY 2007 and FY 2008 claims data, as well as our proposed −1.8 percent documentation and coding adjustment for RY 2010. In that same final rule, we finalized our proposal and established an adjustment of −0.5 percent to account for the documentation and coding increase that occurred in FY 2007. However, after consideration of public comments, and consistent with the decision to postpone the application of the prospective adjustment for estimated FY 2008 documentation and coding increases under the IPPS, we delayed the application of the FY 2008 documentation and coding adjustment of −1.3 percent that was proposed under the LTCH PPS for RY 2010. We also stated our intent to address any future documentation and coding adjustment to the LTCH PPS standard Federal rate based on our analysis of the FY 2008 LTCH claims data in the FY 2011 rulemaking cycle through the notice-and-comment rulemaking process. (74 FR 43970 through 43972)

b. Evaluation of FY 2009 Claims Data

For this proposed rule, we have performed a thorough retrospective evaluation of the most recent available claims data (that is, FY 2009 claims updated through December 2009) using the methodology that was adopted in the FY 2010 IPPS/RY 2010 LTCH PPS final rule and that was used to assess whether an adjustment for RY 2010 to account for changes in documentation and coding practices that occurred in a prior period was appropriate. (We refer readers to the explanation of our rationale for adopting this methodology as well as its intended purpose in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43970 through 43972).)

We performed this analysis by first dividing the CMI obtained by grouping the FY 2009 LTCH claims through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same FY 2009 LTCH claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.0248. Because

this CMI analysis is based on the same FY 2009 cases grouped using the Versions 24.0 and 26.0 of the GROUPER, we attribute this increase in average CMI primarily to two factors: (1) The effect of changes in documentation and coding under the MS–DRG system; and (2) the measurement effect from the calibration of the GROUPER. Next, we estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping the FY 2007 LTCH claims through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same LTCH claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 0.9999. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding measurement (1.0248) by the measurement effect (0.9999) to yield 1.025. Therefore, based on the results of this analysis, we estimate that the cumulative effect of documentation and coding changes that occurred in FYs 2008 and 2009 was 2.5 percent. We note that, in applying the methodology we established for determining the effects of documentation and coding in the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules, we applied such methodology separately to FY 2007 and FY 2008 LTCH claims data because those data were generated under different patient classification systems (that is, FY 2007 was the last year under the CMS LTC–DRGs and FY 2008 was the first year under the MS–LTC–DRGs). Because the same patient classification system was in effect for both FY 2008 and FY 2009 (that is, the MS–LTC–DRGs), consistent with the application of this methodology under the IPPS (discussed in section II.D.5. of this preamble), we believe it is appropriate to propose to apply our established methodology for determining the cumulative effects of documentation and coding for FYs 2008 and 2009, rather than proposing to applying the methodology separately to FY 2008 and FY 2009 LTCH claims data. We seek public comment on our proposal to determine the cumulative effects of documentation and coding in FYs 2008 and 2009. (We note that the FY 2007 and FY 2009 (as well as FY 2008) MedPAR files are available to the public to allow independent analysis of the documentation and coding effect in FYs 2008 and 2009.)

c. Proposed FY 2011 Documentation and Coding Adjustment

Based on analysis of the most recent available LTCH claims data as described above, we are proposing to apply a cumulative adjustment for changes in documentation and coding in a prior period (FYs 2008 and 2009) that do not reflect an increase in patients' severity of illness of −2.5 percent. Accordingly, as discussed in section V.A.2. of the Addendum to this proposed rule, we are proposing to update the proposed FY 2011 LTCH PPS standard Federal rate by −0.1 percent, which is based on the most recent estimate of the market basket increase (2.4 percent) and a proposed adjustment to account for changes in documentation and coding practices (−2.5 percent). We also are proposing that if more recent data are available for the final rule, we would use those data to establish a final update to the FY 2011 LTCH PPS standard Federal rate, if applicable.

D. Proposed Change in Terminology From "Rate Year" to "Fiscal Year" and Other Proposed Changes

Beginning with the annual update to the LTCH PPS that took effect on October 1, 2009, we consolidated the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates with the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights now occur on the same schedule and appear in the same **Federal Register** document. As a result, the updates to the LTCH standard Federal rates and the MS–LTC–DRG relative weights are now effective on October 1 (on a Federal fiscal year schedule), and the annual updates to the LTCH standard Federal rates are no longer published with a July 1 effective date. To reflect this change to the annual payment rate update cycle, we revised the regulations at § 412.503 to specify that, beginning on or after October 1, 2009, the LTCH PPS rate year is defined as October 1 through September 30 (73 FR 26797 through 26798 and 26838).

In this proposed rule, we are proposing to change the terminology used under the LTCH PPS to designate the annual payment update and MS–DRG relative weight recalibration cycle from "rate year" to "fiscal year," in order to conform with the standard definition of the Federal fiscal year (October 1 through September 30) used by the IPPS. We believe that this proposed change is appropriate because both the yearly update cycle of the LTCH standard Federal rates (and associated factors) and the annual reclassification and recalibration of the MS–LTC–DRG relative weights (which were always updated on October 1, consistent with the IPPS) are now concurrent with the IPPS update and implementation schedule of October 1 through September 30. Because the annual updates to both the LTCH standard Federal rates (and associated factors) and the MS–LTC–DRG relative weights now occur at the same time as the annual updates under the IPPS, we believe we would eliminate any possible confusion that may be caused by continuing to identify the LTCH PPS update cycle as a "rate year." We believe that changing the "fiscal year" terminology would provide important clarity for the LTCH provider community, particularly because both the proposed and final rules for the IPPS and the LTCH PPS are generally published in the same **Federal Register** document. Consequently, we are proposing to use the term "fiscal year" when referring to the annual updates for the LTCH standard Federal payment rates and MS–LTC–DRG relative weights as well as to the publication cycle for rulemaking for the LTCH PPS, consistent with the IPPS. We are proposing to revise our definition of "rate year" in the regulations at § 412.503 to reflect this proposed terminology change.

This proposed terminology revision from "rate year" to "fiscal year" would clarify the fact that since October 1, 2003, when we implemented the LTCH PPS, at different times, we have used the terms "rate year" and "fiscal year" when referring to the payment year under the LTCH PPS. In existing regulations at § 412.503, we specify the time periods during which each term was used. We also are proposing to add a definition of "long-term care hospital prospective payment system payment year" to § 412.503 in order to encompass both the long-term care hospital prospective payment system rate year and the long-term care hospital prospective payment system fiscal year. This proposed term would be used when describing ongoing policy features of the LTCH PPS for which, depending upon the time period, either the term "long-term care hospital prospective payment system rate year" or "long-term care hospital prospective payment system fiscal year" would be applicable. We believe that creating this term would minimize confusion by keeping the regulation text as simple as possible because this term would apply to the "long-term care hospital prospective payment system rate year" or to the "long-term care hospital prospective payment system fiscal year." In this respect, existing regulation text (for example, § 412.525(a)) would not need to be revised to address the specific time periods during which the terms "long-

term care hospital prospective payment system rate year" and "long-term care hospital prospective payment system fiscal year" are used.

In addition, as a conforming change, we are proposing to change the terminology in § 412.525(a)(1) and (a)(2), which describes the high-cost outlier policy (an ongoing feature of the LTCH PPS from its inception), from "long-term care hospital prospective payment system rate year" to "long-term care hospital prospective payment system payment year". We believe that this proposed change, which would reference the proposed new definition of the long-term care hospital prospective payment system payment year period at § 412.503, clearly reflects the application of the high-cost outlier policy for the period encompassed by both the current "rate year" terminology and the proposed change to "fiscal year" terminology, described above. We believe that these proposed changes present a straightforward way to provide additional clarity to our regulations in a circumstance that reflects changes in terminology but do not entail any change to the high-cost outlier policy. Furthermore, consistent with this proposal, for purposes of clarity, in this proposed rule, when discussing the annual update for the LTCH PPS, we employ "FY" rather than RY" because it is our intent that "FY" be used prospectively in all circumstances dealing with the LTCH PPS.

VIII. Effective Date of Provider Agreements and Supplier Approvals

A. Background

Section 1866 of the Act states that any provider of services as defined under section 1861(u) of the Act (except a fund designated for purposes of sections 1814(g) and 1835(e) of the Act) shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files with the Secretary a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated into our regulations in 42 CFR part 489, Subparts A and B. Section 1866(b)(2) of the Act provides that the Secretary may refuse to enter into, or may terminate, an agreement with a provider for various reasons, including the provider's failure to comply with the provisions of the agreement and if it has been determined that the provider fails to meet the applicable provisions of section 1861 of the Act, including health and safety standards. Certain suppliers are also required under the Act to meet health and safety standards specified by the Secretary: section 1861(aa)(2)(K), with respect to rural health clinics; section 1832(a)(2)(F)(i), with respect to ambulatory surgical centers; and section 1881(b)(1)(A), with respect to providers of renal dialysis services.

Under section 1864(a) of the Act, the Secretary enters into agreements with State agencies to determine if providers and suppliers meet the requisite Medicare requirements. Section 1865 of the Act permits CMS to "deem" facilities that have been accredited by a national accreditation organization under a CMS-approved accreditation program as having met the Medicare health and safety standards. Section 1871 of the Act authorizes the Secretary to adopt such regulations as may be necessary to carry out the requirements of Title XVIII of the Act.

On August 18, 1997, we adopted regulations, effective September 17, 1997 (1997 final rule), establishing uniform criteria for determining the effective dates of provider agreements and supplier approvals in the Medicare and Medicaid programs (62 FR 43931). Included in these regulations was 42 CFR 489.13, governing the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Facilities subject to survey and certification are those that must comply with Medicare health and safety standards, that is, the conditions of participation (CoPs), long-term care requirements, conditions for coverage (CfC), or conditions for certification, depending on the type of facility. (The regulations exempt clinical laboratories, community mental health centers, and federally qualified health centers from its general provisions, establishing alternative requirements for these entities.) Compliance with the applicable health and safety standards is determined through an onsite survey by a State survey agency, CMS staff, or a CMS contractor, or, in accordance with section 1865 of the Act, CMS may "deem" an entity to have satisfied these requirements if it has been accredited by a national accreditation program approved by CMS. Currently, we have approved 15 accreditation programs offered by 7 national accreditation organizations for the following types of providers or suppliers: Hospitals, CAHs, HHAs, hospices, and ambulatory surgical centers.

Under § 489.13(b) of the regulations, the date the survey is completed is the effective date of the provider agreement or supplier approval, if all applicable Federal requirements have been met on that date. Similarly, § 489.13(d) provides that the effective date for a provider or supplier accredited by a national accreditation organization under a CMS-approved program, and which is subject to additional requirements not contained in the approved program, is the date on which all Federal requirements have been met, including the additional requirements. We have interpreted these provisions to mean not only that the survey/accreditation decision must show that the prospective provider or supplier is in compliance with all of the applicable health and safety standards, but also that all other Federal requirements related to the prospective provider's or supplier's participation in the Medicare program have been met.

Other Federal requirements include, but are not limited to, the submission of an application to enroll in the Medicare program that has been reviewed by our legacy fiscal intermediaries, legacy carriers, or MACs, as applicable, and has been found to meet the enrollment requirements established in 42 CFR part 424, Subpart P. Other Federal requirements also include, for providers, compliance with Office for Civil Rights requirements. There also are additional Federal requirements specific to certain provider types, such as IPPS exclusion requirements for certain types of hospitals, capitalization and surety bond requirements for home health agencies, among others.

Under our current process, section 2003B of the State Operations Manual (SOM) (Publication No. 100–07) states that: "The SA [State Survey agency] should not perform a survey of a new facility until it has received notice from the FI [fiscal intermediary] or carrier that the information provided on the enrollment application has been verified." Section 2005 of the SOM further states: "The MAC/legacy FI will process the Form CMS–855A and the MAC/legacy Carrier will process the Form CMS–855B, depending on which contractor is responsible for processing bills or claims for the provider/supplier. * * * The State Survey Agency will be responsible for surveying initial applicants *following the contractor's recommendation for approval,* and providing the initial certification package." (Emphasis added.)

In accordance with § 488.8(a)(2) of the regulations, one of the requirements for our approval of a national accreditation program is the comparability of its survey process to that of State survey agencies. Consistent with this requirement, in Survey and Certification Policy Memorandum S&C–09–08, dated October 17, 2008, we indicated that a

CMS-approved national accreditation organization also must not conduct a survey of a facility seeking a Medicare provider agreement or supplier approval until after the MAC, the legacy fiscal intermediary, or the legacy carrier has completed its review of the enrollment application and notified the applicant that its review has been completed and a recommendation has been made to CMS.

Therefore, historically, in the normal course of events, the health and safety survey (including the Life Safety Code survey, if applicable) of a prospective provider or supplier has usually occurred after it has demonstrated that it meets the Medicare enrollment requirements, and, as a result, the effective date of a provider agreement or supplier approval is generally later than the date when the contractor has verified that all enrollment requirements have been met. However, on occasion, a survey can take place before the CMS contractor has verified that enrollment requirements have been met. This has tended to happen more frequently in the case of facilities that seek to satisfy Medicare participation requirements through accreditation by a CMS-approved accreditation program, because the accreditation organization relies upon the facility to advise it when it has received notice of completion of the review of its enrollment application. This can result in the date of an accreditation decision preceding the date when the CMS contractor determination has occurred. In addition, in order to prevent fraud and abuse, there may be other situations in which the CMS contractor performs additional enrollment verification activities even after a health and safety survey has been performed.

In cases where the CMS contractor determines that the prospective provider's or supplier's compliance with enrollment requirements did not occur until after a survey by the State survey agency or after the accreditation survey and accreditation decision take place, it is our policy, consistent with our interpretation of § 489.13(b), to make the effective date of the provider agreement or supplier approval the date when the enrollment requirements are considered to have been met, that is, the date determined by the CMS contractor, pursuant to its review and verification activities, to be the date when the applicant is in compliance with all enrollment requirements and the CMS contractor is prepared to convey Medicare billing privileges to the provider or supplier, unless there are still other Federal requirements that remain to be satisfied, such as submission of required civil rights compliance documentation or satisfaction of the specialized requirements governing IPPS-excluded hospitals. If there are other unsatisfied requirements, the effective date would be the date when the last requirement has been satisfied, as determined by CMS.

B. Departmental Appeals Board Decision

In a decision dated September 28, 2009, the Appellate Division of the Departmental Appeals Board (DAB), in the case of *Renal CarePartners of Delray Beach, LLC* v. *Centers for Medicare and Medicaid Services* (DAB Decision No. 2271), rejected our longstanding interpretation of § 489.13(b). In this case, a State survey agency completed an initial certification survey on July 6, 2007, of an end-stage renal disease supplier, Renal CarePartners, prior to the CMS contractor's November 21, 2007 recommendation of approval of the supplier's enrollment application. The DAB concluded that there was no basis in regulation or policy issuances for our position that CMS contractor approval is a requirement a supplier must satisfy "before it may *furnish* services for which it will be reimbursed under Medicare once it is enrolled and obtains billing privileges" (DAB Decision No. 2271, page 2). The DAB further characterized the issue as "* * * not whether the effective date may be earlier than the date Renal CarePartners complied with a prerequisite it was required to meet in order to enroll, but whether the effective date must be delayed until the date the *Medicare contractor* notified CMS that the requirements were met" (DAB Decision No. 2271, page 5) (emphasis in original). The DAB agreed with Renal CarePartners that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the supplier to meet, but a requirement for Medicare contractor action (DAB Decision No. 2271, page 5). The DAB further cited the provisions of § 489.13(d), concerning accredited facilities, as an example to bolster its contention that there is precedent for providers or suppliers to be retroactively reimbursed for services provided before the date of approval of the supplier or provider agreement (DAB Decision No. 2271, page 7).

We disagree with the DAB's reading of our existing regulations. We believe that the intent of the existing regulations is to require that all applicable Federal requirements, including a determination of whether the enrollment requirements have been satisfied, must be met before a provider agreement or supplier approval may be effective. Any other reading of the regulations could result in a provider or supplier being permitted to bill the Medicare program for services provided at a time when its compliance with Medicare's requirements is unknown and possibly deficient. For example, in the event a State survey precedes the CMS contractor's review of the enrollment application of a prospective provider or supplier, it might be possible that the application originally submitted to the CMS contractor is incomplete or incorrect, or both, and the applicant must provide additional information to the CMS contractor to demonstrate compliance with the enrollment requirements. It would not be consistent with our duty to protect the Medicare Trust Funds from unsupported claims against it to permit payment for services furnished by a health care facility after it has passed a State survey or been accredited, but before it has satisfied all other Medicare participation requirements, including enrollment requirements.

Such a reading also might undermine the incentives inherent in our longstanding policy, affirmed in the June 1, 1994 decision of the U.S. Court of Appeals for the Fifth Circuit in *U.S.* v. *Vernon Home Health, Inc.* (21 F.3d 693 (5th Cir. 1994), cert. denied, 115 S.Ct. 575 (1994)). Under that policy, a buyer of a Medicare-participating facility that chooses not to assume the provider agreement or supplier approval of the seller must be treated as an initial applicant to the Medicare program, with a necessary break in Medicare payments for services furnished to beneficiaries during the period between the effective date of the change of ownership, and the effective date of the new owner's provider agreement or supplier approval. Assumption of the seller's provider agreement or supplier approval includes assumption of the assets and liabilities associated with that agreement or approval, which has proven to be an important tool in protecting the Medicare Trust Funds through continuity in the ability to recover outstanding overpayments. Any requirement to make payments retroactive to the date of a State survey or accreditation decision, despite the fact that all other Federal requirements may not yet have been met, could provide an incentive for more buyers to refuse assumption of the seller's provider agreement or supplier approval, because there would potentially be no break in payments. Therefore, effectively, a buyer who does

not assume the seller's active provider agreement could begin receiving Medicare payments (assuming it meets all the requirements), but not be responsible for any existing liabilities of the provider agreement. This would also be an incentive for existing providers or suppliers with civil money penalties or overpayments to sell their facilities in order to escape any financial responsibility to the Medicare program.

C. Proposed Revisions to Regulations

We are proposing to amend § 489.13 and make a technical amendment to § 489.1 in order to clarify our policy. Specifically, we are proposing to revise § 489.13(a) to make it clearer that it is only CMS that determines whether health care facilities have satisfied the requirements for participation in the Medicare program, not State survey agencies or national accreditation organizations. We note that, although this CMS determination is sometimes referred to as a "certification," or "certification decision," § 488.1 defines "certification" as "a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements (for SNFs and NFs), and conditions of coverage." Further, § 488.12 provides that CMS makes the determination on whether a provider or supplier is eligible to participate in or be covered by the Medicare program, based on the State survey agency's recommendation, or on the facility's accreditation.

We also are proposing to add language to § 489.13(a) in order to clarify that surveys of nonaccredited facilities may be conducted not only by State survey agencies, but also by CMS staff or contractors, as appropriate. We have used contractors to conduct certain types of surveys, such as life safety code, transplant program and psychiatric hospital special conditions surveys, and may continue to do so in the future. In addition, certain types of facilities, such as Indian Health Services (IHS) facilities and RNHCIs, have traditionally been surveyed by CMS employees rather than State survey agencies.

We are proposing to revise § 489.13(b) to make explicit that the effective date of a provider agreement or supplier approval may not be earlier than the latest of the dates on which each applicable Federal requirement is determined to be met. We also are proposing to state explicitly that "Federal requirements" include, but are not limited to, the enrollment requirements established in 42 CFR part 424, Subpart P, that have been determined by CMS to have been met. In addition, we are proposing to revise § 489.13(b) to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

We wish to further explain the rationale behind the proposed change to § 489.13(b), particularly with respect to the requirements in the provider/supplier enrollment process.

A CMS contractor will review and conduct an initial assessment of a prospective provider's or supplier's enrollment. If the contractor finds that a prospective provider or supplier meets the basic enrollment requirements to participate in the Medicare program for its identified certified provider or supplier type, the contractor will notify the appropriate CMS Regional Office. Essentially, the contractor's initial assessment means that it has concluded its preliminary review of the application and has concluded that the survey and certification process can be initiated, and, consequently, it issues a recommendation of approval. In order to help ensure compliance with enrollment requirements throughout this process, the contractor may continue to perform a number of enrollment verification tasks even after it has issued a recommendation for approval. These include, but are not limited to, conducting onsite visits of the prospective provider or supplier to ensure that it is still operational; verifying an HHA applicant's compliance with the capitalization provisions in 42 CFR 489.28; and requesting the provider or supplier applicant to reaffirm the accuracy of the information it furnished on its initial enrollment application. Given the potentially significant length of time between when the contractor issues its recommendation of approval after its initial assessment and when the health and safety survey (or accreditation) and certification process is completed, we believe that it is essential for the contractor to verify that a provider or supplier applicant continues to meet enrollment requirements prior to the issuance of a Medicare provider agreement or supplier approval and the issuance of Medicare billing privileges.

To that end, we believe that the CMS contractor should verify that a provider or supplier is in compliance with all enrollment requirements when an enrollment application is submitted, during the period in which a provider or supplier is undergoing the health and safety survey and certification process and before the issuance of a Medicare provider agreement or supplier approval and billing privileges. If a provider or supplier is determined to be in compliance with all Medicare requirements, including the enrollment requirements, the enrollment process will be completed, and the Medicare provider agreement or supplier approval and billing privileges will be issued to the applicant. However, if a provider or supplier is determined to be out of compliance with Medicare enrollment requirements prior to the issuance of a Medicare provider agreement or supplier approval and billing privileges to the applicant, we believe that CMS must deny Medicare billing privileges using the applicable denial reason found in 42 CFR 424.530 and afford the applicant with the applicable Medicare appeal rights.

We are proposing to revise § 489.13(c) to make clear that this paragraph addresses those situations in which a facility has met all other Federal requirements but, upon survey, has been found to not meet all applicable CoPs, long-term care requirements, CfCs, or conditions for certification. We also are proposing to revise this paragraph to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

We are proposing to remove § 489.13(d), concerning the determination of the effective date for accredited facilities. We see no reason for differential treatment of accredited and nonaccredited facilities with respect to the determination of their effective date, and, in practice, we have not treated them differentially. In particular, as a matter of policy, we have not exercised the discretion permitted under § 489.13(d)(2) to grant accredited facilities an effective date retroactive up to 1 year prior to what otherwise would be their effective date. Permitting such retroactive payment would provide accredited facilities an unwarranted advantage when compared to nonaccredited facilities. It would also seriously undermine our policy concerning change of ownership without assumption of the seller's provider agreement or supplier approval. However, the existence of this discretionary provision appears to cause confusion among accredited providers and suppliers who incorrectly believe they are entitled to a retroactive effective date.

This discretionary provision was included in the 1997 final rule as a result of public comments that concerned the Medicaid program. The commenters were concerned that the proposed rule would not have allowed for a retroactive agreement for a facility

that was already accredited and cited two Medicaid program scenarios to illustrate their concern. In one scenario, a facility participates in its own State's Medicaid program and provides services to a Medicaid recipient from another State. In the other scenario, a facility does not participate in Medicaid but provides services to a Medicaid recipient before learning of the individual's Medicaid status. Neither of these scenarios is pertinent to the Medicare program because Medicare enrollment is managed nationally. However, the stated intent of the 1997 final rule was to use a standard approach for both Medicare and Medicaid to determine the effective date of a provider agreement and a supplier approval, and, as a result, the provisions of § 489.13(d)(2) are identical to those at § 431.108(d)(2) for the Medicaid program.

Upon further consideration, we believe it is important to recognize the significant differences resulting from a State-based versus national system of beneficiary enrollment, and to ensure that the provisions of § 489.13 are tailored to the requirements of the Medicare program. As stated, as a matter of longstanding policy, reflected in issuances dating back at least as far as 1994, we have required new owners who do not accept the seller's Medicare provider agreement or supplier approval to be treated as initial applicants to the Medicare program. In a 1999 issuance, reaffirmed in several subsequent issuances, including the 2004 publication of the online version of the SOM and in Survey and Certification Memorandum S&C–09–08 issued on October 17, 2008, we explicitly state that this policy applies to accredited facilities as well. Therefore, we believe it is appropriate to remove § 489.13(d), and to instead make appropriate reference to the situation of accredited facilities in §§ 489.13(b) and (c).

Finally, we are proposing to make several technical amendments to § 489.1. Specifically, we are proposing to revise that section to add a reference to section 1865 of the Act, which permits CMS to "deem" facilities that have been accredited by a national accreditation organization under a CMS-approved accreditation program as having met the Medicare health and safety standards. We also are proposing to revise and renumber the existing provision of § 489.1 and to add references to "the Act" where the section refers to a provision of the Social Security Act.

IX. Proposed Changes to Medicare Conditions of Participation Affecting Hospital Rehabilitation Services and Respiratory Care Services

Recently, CMS received several public requests for clarification of the Medicare conditions of participation (CoPs) for hospitals relating to rehabilitation services at § 482.56 and respiratory care services at § 482.57. The questions concerning these conditions have been in the context of apparent inconsistencies between the two COPs themselves, and between the two CoPs and many State laws, regarding which practitioners are allowed to order rehabilitation and respiratory care services in the hospital setting.

Many States, under their scope-of-practice laws and other regulations, allow qualified, licensed practitioners (including nurse practitioners (NPs) and physician assistants (PAs)) to order rehabilitation services and respiratory care services, in addition to other common hospital services such as dietary and social work services. We also found that most States limit the types of practitioners allowed to order rehabilitation services, respiratory care services, and other hospital services to physicians and other qualified, licensed practitioners such as NPs and PAs.

However, the current standard at § 482.56(b) (Delivery of services) requires only that hospital rehabilitation services (for example, physical therapy, occupational therapy, audiology, and speech-pathology services) be ordered by "practitioners who are authorized by the medical staff to order the services." We believe that this requirement may be too open for interpretation and is not consistent with various State laws that limit the ordering of hospital services (including diagnostic tests, drugs and biologicals, and inpatient treatment modalities) to qualified, licensed practitioners who are responsible for the care of the patient and who are, most importantly, working within a State's delineated scope of practice for these types of practitioners. As this requirement is currently written, it would be conceivable for a hospital's medical staff to grant ordering privileges for rehabilitation services to personnel who are responsible for providing such services, that is, physical therapists, occupational therapists, audiologists, and speech-language pathologists. Such a situation would not only constitute a conflict of interest (for example, a physical therapists ordering physical therapy services for a patient for which medical necessity has not been established), but it would also potentially compromise coordination of care and patient safety if the practitioners who are responsible for the care of patients (that is, doctors of medicine, doctors of osteopathy, NPs, and PAs) are unaware of which services have been ordered for their patients.

Conversely, the current requirement for respiratory care services at § 482.57(b)(3) explicitly states that these services "must be provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy." Similar to our finding that the requirement for the ordering of rehabilitation services is too broad in its parameters for determining which practitioners should be allowed to order those services, we find the parameters for the ordering of respiratory care services to be too narrow. While doctors of medicine or doctors of osteopathy have the option of delegating this task to NPs and PAs, this delegation requires physicians to countersign all orders by NPs or PAs for respiratory care services. We have not found any evidence that indicates that the ordering of respiratory care services should be kept to a different, and possibly higher, standard than rehabilitation and other hospital services. Nor have we found any documented studies indicating that qualified, licensed practitioners such as NPs and PAs should be restricted from ordering these necessary services for their patients. Further, we believe that the process of physician countersignature of orders written by qualified, licensed NPs and PAs, specifically for common hospital services such as rehabilitation and respiratory care services, is burdensome to practitioners (physicians as well as NPs and PAs) and the hospitals that they serve. In addition, we believe that this process also runs counter to what many States have already decided for NPs and PAs in their individual State regulations and scope-of-practice laws.

As a result of our analysis of the issues surrounding conflict of the Medicare CoPs with State laws, and conflict of the Medicare CoP with each other, we are proposing several revisions to the existing regulations. We are proposing to revise § 482.56 to clarify the types of practitioners who are allowed to order rehabilitation services. Further, we are proposing to limit those types of individuals to qualified, licensed practitioners who are responsible for the care of the patient and who are acting within the scope of practice under State law. We also are proposing that these practitioners would need to be authorized to order rehabilitation services by the hospital's medical staff, in accordance with both

hospital policies and procedures and State laws.

In addition, we are proposing changes to the existing requirements for the ordering of respiratory care services at § 482.57. Existing requirements only allow for services to be provided on the orders of a doctor of medicine or osteopathy. As stated above, we recently received several public requests (including requests from various hospitals as well as from The Joint Commission) for clarification of this requirement in the context of what is currently allowed under many State laws. Many States, under their scope-of-practice laws and other regulations, allow qualified, licensed practitioners (including NPs and PAs) to order respiratory care services. We are proposing to revise the existing requirements at § 482.57 to allow these practitioners, in addition to physicians as currently allowed, to order these services as long as such privileges are authorized by the medical staff and are in accordance with both hospital policies and procedures and State laws. As is required under the CoPs for all patient orders, the ordering practitioner must also be an individual who is responsible for the care of the patient.

In both of the CoPs for rehabilitation services and respiratory care services, we also are proposing that all orders for these services be documented in accordance with the requirements at § 482.24, Medical records.

X. Proposed Changes to the Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals Under Age 21

A. Background

Inpatient psychiatric services provided to individuals under the age of 21 were authorized as part of the Medicaid program by the Social Security Amendments of 1972 (Pub. L. 92–603). At that time, these services were only permitted to be provided by psychiatric hospitals accredited by the Joint Commission on Accreditation of Hospitals (later renamed as the Joint Commission on Accreditation of Healthcare Organizations and now named The Joint Commission). In 1984, Congress eliminated the requirement that such hospitals be accredited exclusively by The Joint Commission (section 2340(b) of Pub. L. 98–369).

Through statutory and regulatory amendments, inpatient psychiatric services provided to individuals under the age of 21 were also authorized to be provided in inpatient psychiatric programs within hospitals and in psychiatric facilities other than hospitals, called psychiatric residential treatment facilities (PRTFs). While PRTFs were given flexibility through rulemaking in 1998 to obtain accreditation from several specific accrediting organizations, or any other accrediting body with comparable standards recognized by the State, accreditation by The Joint Commission has remained a requirement for psychiatric hospitals and inpatient psychiatric programs within hospitals.

We have been contacted by several psychiatric hospitals and hospitals with inpatient psychiatric programs asking for relief of The Joint Commission accreditation requirement. In addition, The Joint Commission has previously expressed concern with the mandate for Joint Commission accreditation contained in existing regulation, as its policy is for facilities to seek accreditation voluntarily.

B. Proposed Revision of Policy and Regulations

In response to the concerns described above, we are proposing to remove the requirement that psychiatric hospitals and hospitals with inpatient psychiatric programs providing inpatient psychiatric services to individuals under age 21 must obtain accreditation from The Joint Commission in order to provide these services under the Medicaid program. Under our proposed policy change, psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60 or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. These national accreditation bodies must provide reasonable assurance to CMS that their hospital accrediting programs require adherence to requirements that are at least as stringent as the Medicare requirements.

In addition, we are proposing to revise the accreditation requirements for PRTFs by removing any specific references to accreditation organizations to afford them flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State. This proposed revision would remove specific reference to national accrediting bodies to provide appropriate administrative flexibility to account for any changes in qualifying accrediting organizations. Accrediting bodies approved by CMS must have accrediting requirements for an entity comparable to the CMS requirements for the same entity, and must have survey procedures comparable to those of State survey agencies.

The regulations at 42 CFR 488.4 describe the procedures to be followed by accrediting organizations applying or reapplying for approval of deeming authority for Medicare requirements. The regulations at 42 CFR 488.5(b) and 488.6(b) allow providers and suppliers deemed eligible for Medicare by these accrediting organizations to be also deemed eligible for Medicaid participation in the absence of Medicaid regulations requiring adherence to a different standard. In addition, the regulations at 42 CFR 488.8 detail the procedures that CMS will follow in reviewing and approving national accreditation organizations. Nothing in this proposed rule would alter the implementation of these regulatory provisions.

We believe this flexibility in obtaining accreditation would facilitate the provision of medically necessary, Medicaid-reimbursable psychiatric services to vulnerable children, while maintaining the high quality of care demanded by the Medicaid program. While services may be provided in different settings, the requirements of 42 CFR 441.150 through 441.182 must be adhered to by any provider of services. We are inviting public comments on our suggestions for improving current protections for children.

To incorporate the proposed changes described above in our regulations, we are proposing to revise § 440.160(b)(1) and § 441.151(a)(2)(i) by removing the requirement for accreditation by The Joint Commission of psychiatric hospitals and hospitals with inpatient psychiatric programs. Psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60 or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation by a national accrediting organization whose hospital accrediting program has been approved

by CMS. We are proposing to revise § 440.160(b)(2) and § 441.151(a)(2)(ii) by removing an specific references to accreditation organizations to afford PRTFs the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

XI. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC's recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary's recommendations regarding MedPAC's recommendations. We have reviewed MedPAC's March 2010 "Report to the Congress: Medicare Payment Policy" and have given the recommendations in the report careful consideration in conjunction with the policies set forth in this proposed rule.

MedPAC's Recommendation 2A–1 states that "The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program." This recommendation for the IPPS is discussed in Appendix B to this proposed rule.

MedPAC's Recommendation 2A–2 states that "To restore budget neutrality, the Congress should require the Secretary to fully offset increases in inpatient payments due to hospitals' documentation and coding improvements. To accomplish this goal, the Secretary must reduce payment rates in the inpatient prospective payment system by the same percentage (not to exceed 2 percentage points) each year in 2011, 2012, and 2013. The lower rates would remain in place until overpayments are fully recovered."

Response to Recommendation 2A–2: Beginning in FY 2008, CMS adopted the new MS–DRG patient classification system for the IPPS to better recognize severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The increase in the number of DRGs provides incentives for hospitals to change documentation and coding that can increase Medicare expenditures without any corresponding increase in underlying patient severity. Consistent with the statutory requirement to maintain budget neutrality, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 when the new MS–DRG system was implemented in FY 2008. Subsequent to issuance of the FY 2008 IPPS final rule, section 7 of the TMA of 2007 (Pub. L. 110–90) divided in half the documentation and coding adjustments for the MS–DRG system that we adopted in the FY 2008 IPPS final rule to −0.6 percent for FY 2008 and -0.9 percent for FY 2009. Section 7 requires that, if the implementation of the new MS–DRG payment system resulted in actual changes in documentation and coding in FY 2008 or FY 2009, or both years, that are different from those reflected in the −0.6 percent and −0.9 percent documentation and coding adjustments applied to payment rates in FY 2008 and FY 2009, respectively, the Secretary further adjust operating IPPS rates. This further adjustment must offset the estimated amount of the increase or decrease in aggregate payments for discharges occurring during FY 2008 and FY 2009, and must be made during FY 2010, FY 2011, and/or FY 2012. These adjustments are referred to as the recoupment adjustments and apply only to acute IPPS operating payments. In addition, the law requires that the Secretary eliminate the effect of all actual documentation and coding changes occurring in FY 2008 and FY 2009 incorporated into FY 2010 IPPS operating rates not already accounted for beyond the −0.6 and −0.9 percent adjustments. These adjustments are referred to as the prospective adjustments. As discussed in section II.D. of the preamble of this proposed rule, our current estimate is that an aggregate adjustment of 9.7 percent would be necessary to satisfy these requirements.

We discuss our proposed adjustments to correct for the effects of improved documentation and coding on Medicare payments to hospitals in section II.D. of the preamble of this proposed rule for IPPS operating payments, in section V.E. of the preamble of this proposed rule for IPPS capital payments, and in section VII.C.3. of the preamble of this proposed rule for LTCH PPS payments. In this context, we note that, in considering whether to adopt MedPAC's recommendation, we took into consideration the statutory requirement that the adjustment must offset the estimated amount of the increase or decrease in aggregate payments for discharges occurring during FY 2008 and FY 2009 must be made during FY 2010, FY 2011, and/or FY 2012.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC's Web site at: *http://www.medpac.gov.*

XII. Other Required Information

A. Requests for Data From the Public

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

1. CMS Wage Data Public Use File

This file contains the hospital hours and salaries from Worksheet S–3, Parts II and III from FY 2007 Medicare cost reports used to create the proposed FY 2011 prospective payment system wage index. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

Processing year	Wage data year	PPS Fiscal year
2010	2007	2011
2009	2006	2010
2008	2005	2009
2007	2004	2008

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

Periods Available: FY 2007 through FY 2011 IPPS Update.

2. CMS Occupational Mix Data Public Use File

This file contains the 2007–2008 occupational mix survey data to be used to compute the occupational mix adjustment wage indexes. Multiple versions of this file are created each

year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

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

Period Available: FY 2011 IPPS Update.

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

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

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

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

Period Available: FY 2011 IPPS Update.

4. Other Wage Index Files

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

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

Periods Available: FY 2007 through FY 2011 IPPS Update.

5. FY 2011 IPPS SSA/FIPS CBSA State and County Crosswalk

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

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

Period Available: FY 2011 IPPS Update.

6. HCRIS Cost Report Data

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

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

File Cost: $100.00 per year.

7. Provider-Specific File

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

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

Period Available: FY 2011 IPPS Update.

8. CMS Medicare Case-Mix Index File

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

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

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

Periods Available: FY 1985 through FY 2011.

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

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

- Notice of proposed rulemaking.
- Final rule.

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

Periods Available: FY 2006 through 2011 IPPS Update.

10. IPPS Payment Impact File

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

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

Periods Available: FY 1994 through FY 2011 IPPS Update.

11. AOR/BOR Tables

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

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

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

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

Periods Available: FY 2006 through FY 2011 IPPS Update.

12. Prospective Payment System (PPS) Standardizing File

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

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

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

Period Available: FY 2011 IPPS Update.

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

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

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

2. Requirements in Regulation Text

a. ICRs Regarding Withdrawing an Application, Terminating an Approved 3-Year Reclassification, or Canceling a Previous Withdrawal or Termination (Proposed Revised § 412.273)

Proposed revised § 412.273(b) states that the MGCRB allows a hospital, or group of hospitals, to withdraw its application or to terminate an already existing 3-year reclassification. Proposed revised § 412.273(c) further specifies the timing requirements for the withdrawal or termination requirements. Proposed § 412.273(c)(1) provides that a request for withdrawal must be received by the MGCRB at any time before the MGCRB issues a decision on the application; or after the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of CMS' annual notice of proposed rulemaking concerning changes to the IPPS and proposed payment rates for the fiscal year for which the application has been filed.

The burden associated with this requirement is the time and effort necessary for a hospital to submit a written withdrawal request to the MGCRB. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed revised § 412.273(c)(2) provides that a request for termination must be received by the MGCRB within 45 days of the publication of CMS' annual notice of proposed rulemaking concerning changes to the IPPS and proposed payment rates for the fiscal year for which the termination is to apply. The burden associated with this requirement is the time and effort necessary for a hospital to submit a written termination request to the MGCRB. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed revised § 412.273(d)(1) states that a hospital (or group of hospitals) may cancel a withdrawal or termination in a subsequent year and request the MGCRB to reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period. Proposed revised § 412.273(d)(2) would require that cancellation requests be received in writing by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2). The burden associated with this requirement is the time and effort necessary for a hospital to submit a written request to the MGCRB, requesting that the current withdrawal or termination request be cancelled. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed § 412.273(d)(3) states that a hospital would be able to apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination. The burden associated with the reapplication requirement is the time and effort necessary for a hospital to submit a reclassification request to the MGCRB. While this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

Proposed § 412.273(f)(1) states that a hospital may file an appeal of the MGCRB's denial of its request for withdrawal or termination, or of the MGCRB's denial of its request for a cancellation of such withdrawal or termination, to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial. The burden associated with this requirement is the time and effort necessary for a hospital to file a written appeal of the MGCRB's denial. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The burden associated with collection of information as part of or subsequent to an administrative action is not subject to the PRA.

b. ICRs Regarding Condition of Participation: Respiratory Care Services (§ 482.57)

Proposed § 482.57(b)(4) imposes a recordkeeping requirement. This section would require all respiratory care services orders to be documented in the patient's medical record according to the requirements at § 482.24. The burden associated with this requirement is the time and effort necessary for hospital staff to document and maintain the respiratory care services orders in a patient's medical record. While these requirements are subject to the PRA, the associated burden is exempt from the PRA under 5 CFR 1320.3(b)(2). We believe hospitals will not incur any burden above and beyond that associated with the usual and customary business practice of maintaining detailed patient medical records.

3. Additional Information Collection Requirements

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

a. Present on Admission (POA) Indicator Reporting

Section II.F.6. of the preamble of this proposed rule discusses the POA

indicator reporting program. As stated earlier, collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request 5499 dated May 11, 2007, CMS issued instructions that require IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims.

The burden associated with this requirement is the time and effort necessary to place the appropriate POA indicator codes on Medicare claims. This requirement is subject to the PRA; however, the associated burden is currently approved under OMB control number 0938–0997, with an expiration date of October 31, 2012.

b. Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of this proposed rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold. We detailed the burden associated with this requirement in the September 7, 2001, IPPS final rule (66 FR 46902). As stated in that final rule, collection of the information for this requirement is conducted on an individual case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Similarly, we also believe the burden associated with this requirement is exempt from the PRA under 5 CFR 1320.3(c), which defines the agency collection of information subject to the requirements of the PRA as information collection imposed on 10 or more persons within any 12-month period. This information collection does not impact 10 or more entities in a 12-month period. In FYs 2008, 2009, 2010, and 2011 we received 1, 4, 5, and 3 applications, respectively.

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

As discussed in section V.A. of this proposed rule, the RHQDAPU program was originally established to implement section 501(b) of Public Law 108–173. The RHQDAPU program originally consisted of a "starter set" of 10 quality measures. OMB approved the collection of data associated with the original starter set of quality measures under OMB control number 0938–0918, with a current expiration date of January 31, 2011.

As part of our implementation of section 5001(a) of the DRA, we expanded the number of quality measures reported in the RHQDAPU program. Specifically, section 1886(b)(3)(B)(viii)(III) of the Act, added by section 5001(a) of the DRA, requires that the Secretary expand the "starter set" of 10 quality measures that were established by the Secretary as of November 1, 2003, to include measures "that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings." Under this provision, we established additional program measures to bring the total number of measures to 30. The burden associated with these reporting requirements is currently approved under OMB control number 0938–1022, with a current expiration date of June 30, 2011.

In the FY 2010 IPPS proposed rule (74 FR 24168), we solicited public comments on several considerations for expanding and updating quality measures. We responded to the public comments received in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43866 through 43868). We also expanded and finalized the RHQDAPU program measure set for the FY 2011 payment determination. As part of the expansion effort, we finalized 46 measures in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43872).

In this FY 2011 IPPS/LTCH PPS proposed rule, we are proposing to retire one measure for the FY 2011 payment determination. For the FY 2012 through FY 2014 payment determinations, we are proposing to retain the remaining 45 of the 46 current measures; and for FY 2012, to add 10 new measures and to require all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures; for FY 2013, to retain the FY 2012 measures and add 35 new measures; and for FY 2014, to retain the FY 2013 measures and to add 4 new measures. In addition, we have listed 28 new measures that are under consideration for adoption in future years. We are proposing that beginning with CY 2011 discharges, hospitals submit some of the new measure data to a qualified registry. We are also soliciting public comments on retiring one or more of the 11 additional measures suggested by commenters in the FY 2010 IPPS/RY 2010 LTCH PPS final rule based on topped out performance and other rationales.

In summary, we are proposing to retire one measure for the FY 2011 annual payment update and seeking comments on whether to retire 11 additional measures suggested by commenters in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. In addition, we are proposing to expand the RHQDAPU program measure set to: 55 measures for the FY 2012 annual payment update (taking into account our proposal to retire one measure for the FY 2011 annual payment update); 90 measures for the FY 2013 annual payment update, and 94 measures for the FY 2014 annual payment update. We also list 28 additional measures under consideration for adoption in future years which may increase these numbers if we propose and adopt them in future IPPS rulemaking. Finally, we are proposing that, beginning with the FY 2012 annual payment update, hospitals that participate in the RHQDAPU program submit all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures. This proposal would require hospitals to report these data beginning with CY 2011 discharges.

We submitted a revised version of the information collection request approved under OMB control number 0938–1022, to obtain approval for the proposed new measures.

Section V.A.10. of this proposed rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to CMS to reconsider our decision. The hospital's request for reconsideration must explain the reasons why it believes it satisfied the RHQDAPU program requirements. While this is a reporting requirement, the burden associated with it is not subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information collection requirements imposed subsequent to an administrative action is not subject to the PRA.

d. Proposed Occupational Mix Adjustment to the FY 2011 Index (Hospital Wage Index Occupational Mix Survey)

Section II.D. of the preamble of this proposed rule discusses the proposed occupational mix adjustment to the FY

2011 wage index. While the preamble does not contain any new ICRs, it is important to note that there is an OMB approved information collection request associated with the hospital wage index.

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data at least once every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index. We collect the data via the occupational mix survey.

The burden associated with this information collection requirement is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. The aforementioned burden is subject to the PRA; however, it is currently approved under OMB control number 0938–0907, with an expiration date of February 28, 2013.

e. Hospital Applications for Geographic Reclassifications by the MGCRB

Section III.I.3. of the preamble of this proposed rule discusses revisions to the wage index based on hospital redesignations. As stated in that section, under section 1886(d)(10) of the Act, the MGCRB has the authority to accept short-term IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests by hospitals for geographic reclassification for purposes of payment under the IPPS.

The burden associated with this application process is the time and effort necessary for an IPPS hospital to complete and submit an application for reclassification to the MGCRB. While this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

f. Direct GME Payments: General Requirements

Existing regulations at § 413.75(b) permit hospitals that share residents to elect to form a Medicare GME affiliated group if they are in the same or contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. The purpose of a Medicare GME affiliated group is to provide flexibility to hospitals in structuring rotations under an aggregate FTE resident cap when they share residents. The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the Medicare fiscal intermediary or MAC servicing the hospital and send a copy to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

In section V.H.3. of the preamble of this proposed rule, we are proposing to allow hospitals to electronically submit the copy of the affiliation agreement that is required to be sent to the CMS Central Office. As stated earlier in the preamble, the proposed electronic submission process would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office to a designated online mailbox. We are proposing that a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display (PDF) version of that hard copy agreement; we are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75. Under this proposal, hospitals would have the option to continue to submit a hard copy of its affiliation agreement to the CMS Central Office. In addition, each fiscal intermediary or MAC would continue to have the authority to specify its requirements for submittal of the Medicare GME affiliation agreement by hospitals that are part of the affiliation.

The burden associated with this requirement is the time and effort it would take for the new hospital to develop and submit the Medicare GME affiliation agreement, to submit it the agreement to its fiscal intermediary or MAC, and to submit a copy to CMS. In the proposed and final rules that published on May 22, 2009 (74 FR 24080) and August 27, 2009 (74 FR 43754), we stated that it was difficult for us to estimate the annual burden associated with this requirement because we cannot estimate the additional number of hospitals that will be permitted to submit Medicare GME affiliation agreements in any given year as a result of the change. However, we now have better data available to quantify the burden associated with the existing requirement for hospitals to submit GME affiliation agreements to the fiscal intermediary or MAC servicing the hospital and new requirement for the electronic submission of a copy of the affiliation agreement to CMS. We are submitting a new information collection request to OMB for review and approval of the associated burden.

We anticipate receiving between 100 and 150 GME affiliation agreements annually. For the purposes of our information collection request, we estimate that we will receive 125 agreements annually. CMS provides a two-page sample agreement for hospitals; however, some facilities may submit additional information that is not required. We estimate that it will take 1 hour for a hospital to develop a GME affiliation agreement or to follow the format provided by CMS. Similarly, we estimate that it will take each hospital 15 minutes to submit a hard copy of the affiliation agreement to its fiscal intermediary or MAC. Finally, we estimate that it will take each hospital 5 minutes to submit an electronic copy of its GME affiliation agreement to CMS. The total annual burden associated with developing the affiliation agreement is 125 hours. The total annual burden associated with submitting a hard copy of the affiliation agreement is 31 hours. The total annual burden associated with submitting the agreement electronically is 10 hours. The total annual burden associated with all of the requirements in this section is 166 hours. The total cost associated with this requirement is $5,000 ($40.00 x 125 agreements).

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

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

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS–1498–P; Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov*.

C. Response to Comments

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

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 440

Grant program-health, Medicaid.

42 CFR Part 441

Family planning, Grant program-health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and rcordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

2. Section 412.4 is amended by—

a. Republishing the introductory language of paragraph (b).

b. Removing the word "or" at the end of paragraph (b)(1).

c. Removing the period at the end of paragraph (b)(2) and adding in its place a semicolon.

d. Adding new paragraphs (b)(3) and (b)(4).

The additions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

* * * * *

(3) An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program; or

(4) A critical access hospital.

* * * * *

§ 412.106 [Amended]

3. Section 412.106 is amended by—

a. In paragraph (b)(2)(i)(B), removing the word "or" and adding in its place the word "including".

b. In paragraph (b)(2)(iii)(B), removing the word "or" and adding in its place the word "including".

§ 412.108 [Amended]

4. Amend § 412.108 (a)(1)(iii) introductory text by removing the word "receiving" and adding in its place the words "entitled to".

5. Section 412.113 is amended by revising paragraph (c)(2)(i)(A) to read as follows:

§ 412.113 Other payments.

* * * * *

(c) * * *

(2)(i) * * *

(A) The hospital or CAH is located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3). For cost reporting periods beginning on or after October 1, 2010, the hospital or CAH is either located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at § 412.103.

* * * * *

6. Section 412.273 is revised to read as follows:

§ 412.273 Withdrawing an application, terminating an approved 3-year reclassification, or canceling a previous withdrawal or termination.

(a) *Definitions.* For purposes of this section, the following definitions apply.

Termination refers to the termination of an already existing 3-year MGCRB reclassification where such reclassification has already been in effect for 1 or 2 years, and there are 1 or 2 years remaining on the 3-year reclassification. A termination is effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered.

Withdrawal refers to the withdrawal of a 3-year MGCRB reclassification that has not yet gone into effect or where the MGCRB has not yet issued a decision on the application.

(b) *General rule.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application or to terminate an already existing 3-year reclassification, in accordance with this section.

(c) *Timing.* (1) A request for withdrawal must be received by the MGCRB—

(i) At any time before the MGCRB issues a decision on the application; or

(ii) After the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of CMS' annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application has been filed.

(2) A request for termination must be received by the MGCRB within 45 days of the publication of CMS' annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

(d) *Reapplication within the approved 3-year period, cancellations of terminations and withdrawals, and prohibition on overlapping reclassification approvals.*

(1) *Cancellation of terminations or withdrawals.* Subject to the provisions of this section, a hospital (or group of hospitals) may cancel a withdrawal or termination in a subsequent year and request the MGCRB to reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period. (Withdrawals may be cancelled only in cases where the MGCRB issued a decision on the geographic reclassification request.)

(2) *Timing and process of cancellation request.* Cancellation requests must be received in writing by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2).

(3) *Reapplications.* A hospital may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or

termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination.

(4) *Termination of existing 3-year reclassification.* In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1.

(e) *Written request only.* A request to withdraw an application must be made in writing to the MGCRB by all hospitals that are party to the application. A request to terminate an approved reclassification may be made in writing to the MGCRB by an individual hospital or by an individual hospital that is party to a group classification.

(f) *Appeal of the MGCRB's denial of a hospital's request for withdrawal or termination, or for cancellation of a withdrawal or termination.*

(1) A hospital may file an appeal of the MGCRB's denial of its request for withdrawal or termination, or of the MGCRB's denial of its request for a cancellation of such withdrawal or termination, to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

7. Section 412.503 is amended by—

a. Adding a definition of "long-term care hospital prospective payment system fiscal year".

b. Adding a definition of "long-term care hospital prospective payment system payment year".

c. Revising paragraph (3) of the definition of "long-term care hospital prospective payment system rate year".

The additions and revision read as follows:

§ 412.503 Definitions.

* * * * *

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of "long-term care hospital prospective payment system rate year" and "long-term care hospital prospective payment system fiscal year" specified in this section.

Long-term care hospital prospective payment system rate year means—

* * * * *

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

* * * * *

8. Section 412.523 is amended by adding a new paragraph (c)(3)(vii) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rate.

* * * * *

(c) * * *

(3) * * *

(vii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011.* The standard Federal rate for the long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011, is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by −0.1 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

9. Section 412.525 is amended by revising paragraphs (a)(1) and (a)(2) to read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* (1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC–MS–DRG payment plus a fixed-loss amount. For each long-term care hospital prospective payment system payment year, as described in § 412.503, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital prospective payment system payment year, as defined in § 412.503, using the LTC–MS–DRG relative weights that are in effect at the start of the applicable long-term care hospital prospective payment system payment year, as defined in § 412.503.

* * * * *

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

10. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

11. Section 413.70 is amended by—

a. Revising paragraph (b)(3)(i)(A).

b. Revising paragraph (b)(3)(i)(B).

c. Revising paragraph (b)(3)(i)(D).

The revisions read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(3) * * *

(i) * * *

(A)(*1*) *For cost reporting periods beginning before October 1, 2010.* The election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. An election, once made for a cost reporting period, remains in effect for all of that period.

(*2*) *For cost reporting periods beginning on or after October 1, 2010.* If a CAH had elected the method specified in paragraph (b)(3)(i) of this section in its most recent cost reporting period beginning prior to October 1, 2010, that election remains in effect for all of that period and for all subsequent cost reporting periods, unless the CAH submits a termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the next cost reporting period. If a CAH had not, in its most recent cost reporting period, elected the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section and chooses to elect this method on or after October 1, 2010, the election must be made in writing and delivered to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the first cost reporting period for which the election is made. Once the election is made, it remains in effect for all of that period and for all subsequent cost reporting periods unless the CAH submits a termination request to the fiscal intermediary or MAC servicing

the CAH at least 30 days before the start of the next cost reporting period. For cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its election, the CAH must submit a termination request to the fiscal intermediary or MAC servicing the CAH prior to December 1, 2010.

(B) An election of the payment method specified under paragraph (b)(3)(i) of this section applies to all services furnished to outpatients by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with subpart F of Part 424 of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with subpart F of Part 424 of this chapter, payment for the physician's or practitioner's services furnished to CAH outpatients will be made on a fee schedule or other applicable basis as specified in subpart B of Part 414 of this subchapter.

* * * * *

(D) An election made under paragraph (b)(3)(i) of this section is effective as provided for under paragraph (b)(3)(i)(A) or paragraph (b)(3)(i)(C) of this section and does not apply to an election that was terminated prior to the start of the cost reporting period for which it would otherwise apply.

* * * * *

12. Section 413.75 is amended by revising the definitions of "Primary care resident" and "Resident" under paragraph (b) to read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Primary care resident is a resident who is enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice. Effective for cost reporting periods beginning on or after October 1, 2010, *primary care resident* is a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

* * * * *

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Effective for cost reporting periods beginning on or after October 1, 2010, *resident* means an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

* * * * *

PART 440—SERVICES: GENERAL PROVISIONS

13. The authority citation for Part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

18. Section 440.160 is amended by revising paragraphs (b)(1) and (b)(2) to read as follows:

§ 440.160 Inpatient psychiatric services for individuals under age 21.

* * * * *

(b) * * *

(1) A psychiatric hospital that meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS, or a hospital with an inpatient psychiatric program that meets the requirements for participation in Medicare as a hospital as specified in Part 482 of this chapter or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(2) A psychiatric facility that is not a hospital and is accredited by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

14. The authority citation for Part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

15. Section 441.151 is amended by revising paragraphs (a)(2)(i) and (a)(2)(ii) to read as follows:

§ 441.151 General requirements.

(a) * * *

(2) * * *

(i) A psychiatric hospital that meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS, or a hospital with an inpatient psychiatric program that meets the requirements for participation in Medicare as a hospital as specified in Part 482 of this chapter or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(ii) A psychiatric facility that is not a hospital and is accredited by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

16. The authority citation for Part 482 continues to read as follows:

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

17. Section 482.56 is amended by revising paragraph (b) to read as follows:

§ 482.56 Condition of participation: Rehabilitation services.

* * * * *

(b) *Standard: Delivery of services.* Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient's medical record according to the requirements at § 482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of § 409.17 of this chapter.

18. Section 482.57 is amended by revising paragraph (b)(3) and adding paragraph (b)(4) to read as follows:

§ 482.57 Condition of participation: Respiratory care services.

* * * * *

(b) * * *

(3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the

services in accordance with hospital policies and procedures and State laws.

(4) All respiratory care services orders must be documented in the patient's medical record according to the requirements at § 482.24.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

19. The authority citation for Part 485 continues to read as follows:

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

20. Section 485.610 is amended by revising the introductory text of paragraph (b) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(b) *Standard: Location in a rural area or treatment as rural.* The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of either (b)(3) or (b)(4) of this section.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

21. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

22. Section 489.1 is revised to read as follows:

§ 489.1 Statutory basis.

(a) This part implements section 1866 of the Social Security Act (the Act). Section 1866 of the Act specifies the terms of provider agreements, the grounds for terminating a provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The sections of the Act specified in paragraphs (a)(1) through (a)(4) of this section are also pertinent.

(1) Section 1861 of the Act defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(2) Section 1864 of the Act provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(3) Section 1865(a)(1) of the Act provides that an entity accredited by a national accreditation body found by the Secretary to satisfy the Medicare conditions of participation, conditions for coverage, or conditions of certification or requirements for participation shall be treated as meeting those requirements. Section 1865(a)(2) of the Act requires the Secretary to consider when making such a finding, among other things, the national accreditation body's accreditation requirements and survey procedures.

(4) Section 1871 of the Act authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(b) Although section 1866 of the Act speaks only to providers and provider agreements, the effective date rules in this part are made applicable also to the approval of suppliers that meet the requirements specified in § 489.13.

(c) Section 1861(o)(7) of the Act requires each HHA to provide CMS with a surety bond.

23. Section 489.13 is revised to read as follows:

§ 489.13 Effective date of agreement or approval.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare are subject to a determination by CMS on the basis of—

(i) A survey conducted by the State survey agency or CMS staff surveyors; or

(ii) Accreditation by an accreditation organization whose program has CMS approval at the time of the accreditation survey and accreditation decision.

(2) *Exceptions.* (i) For an agreement with a community mental health center (CMHC) or a federally qualified health center (FQHC), the effective date is the date on which CMS accepts a signed agreement which assures that the CMHC or FQHC meets all Federal requirements.

(ii) A Medicare supplier approval of a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under Part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform.

(b) *All health and safety standards are met on the date of survey.* The agreement or approval is effective on the date the State agency, CMS staff, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the date of the accreditation decision, as applicable, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. (If the agreement or approval is time-limited, the new agreement or approval is effective on the day following the expiration of the current agreement or approval.) However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to—

(1) Enrollment requirements established in Part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

(2) The requirements identified in §§ 489.10 and 489.12; and

(3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

(c) *All health and safety standards are not met on the date of survey.* If, on the date the survey is completed, the provider or supplier has failed to meet any one of the applicable health and safety standards, the following rules apply for determining the effective date of the provider agreement or supplier approval, assuming that no other Federal requirements remain to be satisfied. The effective date of the agreement or approval may not be earlier than the latest of the dates on which each applicable Federal requirement is met.

(1) For an agreement with an SNF, the effective date is the date on which—

(i) The SNF is in substantial compliance (as defined in § 488.301 of this chapter) with the requirements for participation; and

(ii) CMS or the State survey agency receives from the SNF, if applicable, an approvable waiver request.

(2) For an agreement with, or an approval of, any other provider or supplier, (except those specified in paragraph (a)(2) of this section), the effective date is the earlier of the following:

(i) The date on which the provider or supplier meets all applicable conditions of participation, conditions for coverage, or conditions for certification; or, if applicable, the date of a CMS-approved accreditation organization program's positive accreditation decision, issued after the accreditation organization has determined that the provider or supplier meets all applicable conditions.

(ii) The date on which a provider or supplier is found to meet all conditions of participation, conditions for coverage,

or conditions for certification, but has lower-level deficiencies, and—

(A) CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies (the date of receipt is the effective date regardless of when the plan of correction is approved); or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or

(B) CMS receives an approvable waiver request (the date of receipt is the effective date regardless of when CMS approves the waiver request).

(C) For an agreement with any other provider or an approval of any other supplier (except those specified in paragraph (a)(2) of this section) that is found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies and has submitted both an approvable plan of correction/positive accreditation decision and an approvable waiver request, the effective date is the later of the dates that result when calculated in accordance with paragraph (c)(2)(ii)(A) or (c)(2)(ii)(B) of this section.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; and Program No. 93.778, Medical Assistance)

Dated: April 6, 2010.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 16, 2010.

Kathleen Sebelius,

Secretary.

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

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2010

I. Summary and Background

In this Addendum, we are setting forth a description of the methods and data we used to determine the proposed prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs for FY 2011 for acute care hospitals. We note that on March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

We also are setting forth the proposed rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS for FY 2011. We note that, because certain hospitals excluded from the IPPS are paid on a reasonable cost basis subject to a rate-of-increase ceiling (and not by the IPPS), these hospitals are not affected by the figures for the standardized amounts, offsets, and budget neutrality factors. Therefore, in this proposed rule, we are proposing to establish the rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS that are effective for cost reporting periods beginning on or after October 1, 2010.

In addition, we are setting forth a description of the methods and data we used to determine the proposed standard Federal rate that will be applicable to Medicare LTCHs for FY 2011.

In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, also known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever was higher. However, section 5003(a)(1) of Public Law 109–171 extended and modified the MDH special payment provision that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Public Law 109–171, if the change results in an increase to an MDH's target amount, we must rebase an MDH's hospital-specific rates based on its FY 2002 cost report. Section 5003(c) of Public Law 109–171 further required that MDHs be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based on the provisions of section 5003(d) of Public Law 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

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

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for acute care hospitals for FY 2011. In section III. of this Addendum, we discuss our proposed policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2011. In section IV. of this Addendum, we are setting forth our proposed changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2011. In section V. of this Addendum, we are proposing to make changes in the determination of the standard Federal rate for LTCHs under the LTCH PPS for FY 2011. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2011

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the proposed prospective payment rates for FY 2011.

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

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act.
- Proposed updates of 2.4 percent for all areas (that is, the estimated full market basket percentage increase of 2.4 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner, and at the time specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- A proposed update of 2.4 percent to the Puerto Rico-specific standardized amount (that is, the full estimated rate-of-increase in the hospital market basket for IPPS hospitals), as provided for under § 412.211(c), which states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas.
- An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.
- An adjustment to ensure the wage index changes are budget neutral, as provided for under section 1886(d)(3)(E)(i) of the Act. We note that section 1886(d)(3)(E)(i) of the Act requires that we do not consider the labor-related share of 62 percent to compute wage index budget neutrality.
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2010 budget neutrality factor and applying a revised factor.
- An adjustment to remove the FY 2010 outlier offset and apply an offset for FY 2011, as provided for in section 1886(d)(3)(B) of the Act.
- As discussed below and in section II.D. of the preamble to this proposed rule, an adjustment to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts to offset the estimated amount of the increase in aggregate payments (including interest) due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009.

For FY 2011 (in the absence of the provisions of Public Law 111–148 as amended by Pub. L. 111–152), the requirement under section 410A of Public Law 108–173 to conduct a rural community hospital demonstration program and under section 410A(c)(2) of Public Law 108–173 to adjust the standardized amount to ensure the effects of the rural community hospital demonstration are budget neutral has expired. Therefore, for this proposed rule, there is no adjustment applied to the standardized amount to ensure the effects of the rural community hospital demonstration are budget neutral.

We note that, beginning in FY 2008, we applied the budget neutrality adjustment for the rural floor to the hospital wage indices rather than the standardized amount. As we did for FY 2010, for FY 2011, we are proposing to continue to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amount, for FY 2011, we are proposing to continue to apply the imputed floor budget neutrality adjustment to the wage indices. Consistent with the policy we established in the FY 2009 IPPS final rule (in absence of the provisions of Pub. L. 111–148, as amended by Pub. L. 111–152), we also are proposing to continue to apply the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality changes concerning the rural floor and the imputed floor, including the within-State budget neutrality adjustment, we refer readers to section III.B.2. of the preamble of the FY 2009 IPPS final rule and this proposed rule.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

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

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

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized

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

For FY 2011, we are proposing to continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2010 for the national standardized amounts and 62.1 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all IPPS hospitals whose wage index values are less than or equal to 1.0000. For all IPPS hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 68.8 percent of the national standardized amount. For FY 2011, all Puerto Rico hospitals have a wage index less than 1.0. Therefore, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0.

For hospitals located in Puerto Rico, we are applying a labor-related share of 62.1 percent if its Puerto Rico-specific wage index is greater than 1.0000. For hospitals located in Puerto Rico whose Puerto-Rico specific wage index values are less than or equal to 1.0000, we are applying a labor share of 62 percent.

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

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are proposing to calculate the FY 2011 national and Puerto Rico standardized amounts irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are proposing to update the equalized standardized amount for FY 2011 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171. The percentage increase in the market basket reflects the average change in the price of goods and services comprising routine, ancillary, and special care unit hospital inpatient services. The most recent forecast of the hospital market basket increase for FY 2011 is 2.4 percent. Thus, for FY 2011, the proposed update to the average standardized amount is 2.4 percent for hospitals in all areas. The estimated market basket increase of 2.4 percent is based on IHS Global Insight, Inc.'s 2010 first quarter forecast of the hospital market basket increase (as discussed in Appendix B of this proposed rule).

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

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the proposed update to the Puerto Rico-specific standardized amount is 2.4 percent.

Although the update factors for FY 2011 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2011 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Section 1886(e)(5)(A) of the Act requires that we publish our proposed recommendations in the **Federal Register** for public comment. Our recommendation on the update factors is set forth in Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2011 standardized amount to remove the effects of the FY 2010 geographic reclassifications and outlier payments before applying the FY 2011 updates. We then apply budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2011 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after updates in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year's adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters.

Similar to last year, because IME Medicare Advantage payments are made to IPPS hospitals under section 1886(d) of the Act, we believe these payments must be part of these budget neutrality calculations. However, we note that it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation or the outlier offset to the standardized amount because the statute requires that outlier payments be not less than 5 percent nor more than 6 percent of total "operating DRG payments," which does not include IME and DSH payments. In order to account for these Medicare Advantage IME payments in determining the budget neutrality adjustments for this proposed rule, we identified Medicare Advantage claims from IPPS teaching hospitals in the MedPAR data. The GHO Paid indicator with a value of "1" on the MedPAR file indicates that the claim was paid by a Medicare Advantage plan

(other than the IPPS IME payment specified at § 412.105(g)). For these Medicare Advantage claims from IPPS teaching hospitals, we computed a transfer-adjusted CMI by provider based on the FY 2009 MS–DRG GROUPER Version 27.0 assignment and relative weights. We also computed a transfer-adjusted CMI for these Medicare Advantage claims from IPPS teaching hospitals based on the FY 2010 MS–DRG GROUPER Version 28.0 assignments and relative weights. These transfer-adjusted CMIs (and corresponding case counts) were used to calculate an IME teaching add-on payment in accordance with § 412.105(g). The total Medicare Advantage IME payment amount was then added to the total Federal payment amount for each provider (where applicable) in order to account for the Medicare Advantage IME payment in determining the budget neutrality adjustments. We note that we did not include Medicare Advantage IME claims when estimating outlier payments for providers because Medicare Advantage claims are not eligible for outlier payments under the IPPS.

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

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

Section 1886(d)(3)(E)(i) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. Section 1886(d)(3)(E)(i) of the Act requires that we implement the wage index adjustment in a budget neutral manner. However, section 1886(d)(3)(E)(ii) of the Act sets the labor-related share at 62 percent for hospitals with a wage index less than or equal to 1.0, and section 1886(d)(3)(E)(i) of the Act provides that the Secretary shall calculate the budget neutrality adjustment for the adjustments or updates made under that provision as if section 1886(d)(3)(E)(ii) of the Act had not been enacted. In other words, this section of the statute requires that we implement the updates to the wage index in a budget neutral manner, but that our budget neutrality adjustment should not take into account the requirement that we set the labor-related share for hospitals with indices less than or equal to 1.0 at the more advantageous level of 62 percent. Therefore, for purposes of this budget neutrality adjustment, section 1886(d)(3)(E)(i) of the Act prohibits us from taking into account the fact that hospitals with a wage index less than or equal to 1.0 are paid using a labor-related share of 62 percent. Consistent with current policy, for FY 2011, we are proposing to adjust 100 percent of the wage index factor for occupational mix. We describe the proposed occupational mix adjustment in section III.D. of the preamble of this proposed rule.

For FY 2011, to comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral for the Puerto Rico standardized amount and the hospital-specific rates, we used FY 2009 discharge data to simulate payments and compared aggregate payments using the FY 2010 labor-related share percentages, the FY 2010 relative weights, and the FY 2010 pre-reclassified wage data to aggregate payments using the FY 2010 labor-related share percentages, the proposed FY 2011 relative weights, and the FY 2010 pre-reclassified wage data. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.996963. As discussed in section IV. of this Addendum, we would also apply the proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2010.

In order to meet the statutory requirements that we do not take into account the labor-related share of 62 percent when computing wage index budget, it was necessary to use a three-step process to comply with the requirements that DRG reclassification and recalibration of the relative weights and the updated wage index and labor-related share have no effect on aggregate payments for IPPS hospitals. We first determined a proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 by using the same methodology described above to determine the proposed DRG reclassification and recalibration budget neutrality factor for the Puerto Rico standardized amount and hospital-specific rates. Secondly, to compute a budget neutrality factor for wage index and labor-related share changes, we used FY 2009 discharge data to simulate payments and compared aggregate payments using proposed FY 2011 relative weights and FY 2010 pre-reclassified wage indices, and applied the FY 2010 labor-related share of 68.8 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0) to aggregate payments using the proposed FY 2011 relative weights and the proposed FY 2011 pre-reclassified wage indices, and applied the labor-related share for FY 2011 of 68.8 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0). In addition, we applied the proposed DRG reclassification and recalibration budget neutrality factor (derived in the first step) to the rates that were used to simulate payments for this comparison of aggregate payments from FY 2010 to FY 2011. By applying this methodology, we determined a proposed budget neutrality factor of 1.000107 for changes to the wage index. Finally, we multiplied the proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 (derived in the first step) by the proposed budget neutrality factor of 1.000107 for changes to the wage index (derived in the second step) to determine the proposed DRG reclassification and recalibration and updated wage index budget neutrality factor of 0.996963.

b. Reclassified Hospitals—Proposed Budget Neutrality Adjustment

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of

sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account "in applying any budget neutrality adjustment with respect to such index" under section 1886(d)(8)(D) of the Act. To calculate the proposed budget neutrality factor for FY 2011, we used FY 2009 discharge data to simulate payments and compared total IPPS payments with proposed FY 2011 relative weights, FY 2011 labor share percentages, and proposed FY 2011 wage data prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments with proposed FY 2011 relative weights, FY 2011 labor share percentages, and proposed FY 2011 wage data after such reclassifications. Based on these simulations, we calculated a proposed adjustment factor of 0.991756 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The proposed FY 2011 budget neutrality adjustment factor is applied to the standardized amount after removing the effects of the FY 2010 budget neutrality adjustment factor. We note that the proposed FY 2011 budget neutrality adjustment reflects proposed FY 2011 wage index reclassifications approved by the MGCRB or the Administrator. Furthermore, for this proposed rule, we note that the proposed FY 2011 wage index reclassifications approved by the MGCRB or the Administrator are in the absence of the provisions of Public Law 111–148, as amended by Public Law 111–152.

c. Proposed Rural Floor and Imputed Floor Budget Neutrality Adjustment

CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the BBA (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) of the regulations are made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule (73 FR 48570 through 48574), we adopted as final State-level budget neutrality for the rural and imputed floors, effective beginning with the FY 2009 wage index. In response to the public's concerns and taking into account the potentially significant payment cuts that could occur to hospitals in some States if we implemented this change with no transition, we decided to phase in, over a 3-year period, the transition from the national rural floor budget neutrality adjustment on the wage index to the State-level rural floor budget neutrality adjustment on the wage index. In FY 2009, hospitals received a blended wage index that was comprised of 20 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 80 percent of the wage index adjusted by applying the national budget neutrality adjustment. For FY 2010, the blended wage index was determined by adding 50 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 50 percent of the wage index adjusted by applying the national budget neutrality adjustment. In FY 2011 (in the absence of provisions of Pub. L. 111–148, as amended by Public Law 111–152), the proposed adjustment will be completely transitioned to the State-level methodology, such that the wage index will be determined by applying 100 percent of the State-level budget neutrality adjustment. As stated earlier, we note that the rural floor budget neutrality adjustment is applied to the wage index and not the standardized amount. However, because the 100 percent State-level rural and imputed floor budget neutrality adjustment is used in calculating the proposed FY 2011 outlier threshold (as discussed below), we are explaining our calculation of the proposed rural floor budget neutrality adjustments (in this section) below.

In order to compute a budget neutral wage index that is 100 percent of the wage index adjusted by the State-level rural and imputed floor budget neutrality adjustment, we used FY 2009 discharge data with proposed FY 2011 relative weights, proposed FY 2011 labor share percentages, and proposed FY 2011 post reclassified wage indices to simulate IPPS payments. To determine each State's rural or imputed floor budget neutrality adjustment, we compared each State's total simulated payments with and without the rural or imputed floor applied. These State-level rural and imputed floor budget neutrality factors were then applied to the wage indices to produce a State-level rural and imputed floor budget neutral wage index, which was used in determining the FY 2011 wage indices.

d. Proposed Case-Mix Budget Neutrality Adjustment

(1) Adjustment to the FY 2011 IPPS Standardized Amount

As stated earlier, beginning in FY 2008, we adopted the MS–DRG patient classification system for the IPPS to better recognize patients' severity of illness in Medicare payment rates. In the FY 2008 IPPS final rule with comment period (73 FR 47175 through 47186), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. In that final rule, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in documentation and coding that do not reflect real change in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 (for a total adjustment of −4.8 percent). On September 29, 2007, Public Law 110–90 was enacted. Section 7 of Public Law 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with the provision of section 7(a) of Public Law 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 national standardized amounts (as well as other payment factors and thresholds) accordingly, with these revisions being effective as of October 1, 2007. For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment specified in the FY 2008 IPPS final rule with comment period. As required by statute, we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment

in FY 2008, yielding a combined effect of −1.5 percent.

In the FY 2010 IPPS proposed and final rules, we discussed our analysis of FY 2008 claims data which showed an increase in case-mix of 2.5 percent due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008. For FY 2010, we proposed to reduce the average standardized amounts under section 1886(d) of the Act in FY 2010 by −1.9 percent, which represents the difference between changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and the prospective adjustment applied under Public Law 110–90. As discussed in section II.D. of the preamble of the FY 2010 IPPS final rule, after consideration of the public comments we received on our analysis and proposals presented in the proposed rule, we decided to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of FY 2009 case-mix changes could be completed. Accordingly, in the FY 2010 IPPS final rule, for FY 2010, we did not apply any additional documentation and coding adjustments to the average standardized amounts under section 1886(d) of the Act.

As indicated in section II.D.in the preamble to this proposed rule, the change due to documentation and coding that did not reflect real changes in case mix for discharges occurring during FY 2008 and FY 2009 exceeded the −0.6 and −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 for those 2 years respectively by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points. Our actuaries currently estimate that this 5.8 percentage point increase resulted in an increase in aggregate payments of approximately $6.9 billion. Therefore, an aggregate adjustment of −5.8 percent in FYs 2011 and 2012, subject to actuarial adjustment to reflect accumulated interest, is necessary in order to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of the cumulative increase in aggregate payments (including interest) in FYs 2008 and 2009. We refer the reader to section II.D. of the preamble to this proposed rule for more discussion.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, we are proposing to make an adjustment to the standardized amount of −2.9 percent, representing half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. As we have previously noted, unlike the prospective adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, the recoupment or repayment adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures. We note that we are not making a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in this proposed rule.

(2) Proposed Adjustment to the FY 2011 Hospital-Specific Rates for SCHs and MDHs

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

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, based on our analysis of FY 2008 claims data, we found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the 2.5 percent result discussed earlier, but did not significantly differ from that result.

Therefore, in FY 2010, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by −2.5 percent in FY 2011 for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We also noted that, unlike the national standardized rates, the FY 2010 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

Consistent with our approach for determining the national average standardized amounts discussed earlier, after consideration of the public comments we received on our analysis and proposals presented in the FY 2010 IPPS proposed rule, for FY 2010, we also postponed adoption of a documentation and coding adjustment to the hospital-specific rate until a full analysis of FY 2009 case-mix changes could be completed. Accordingly, for FY 2010, we did not apply a documentation and coding adjustment to the hospital-specific rates.

As we discuss in section II.D. of the preamble of this proposed rule, because SCHs and MDHs use the same DRG system as all other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. While the findings of the effects documentation and coding are different for SCHs/MDHs and other IPPS hospitals, we continue to believe that the documentation and coding adjustments for all subsection (d) hospitals should be the same. We continue to believe that this is the appropriate policy so as to neither advantage nor disadvantage different types of providers.

As we have also discussed in section II.D. of the preamble to this proposed rule, our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent

is required to eliminate the full effect of the documentation and coding changes on future payments. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire −5.4 percent adjustment remains to be implemented. Therefore, in order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals, we are proposing an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity between hospitals paid on the basis of different prospective rates.

(3) Proposed Adjustment to the FY 2011 Puerto Rico Standardized Amount

As stated in section II.D. of the preamble of this proposed rule, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. In the FY 2010 IPPS proposed rule, we discussed our analysis of FY 2008 claims data for Puerto Rico hospitals, which showed that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding changes that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent. We noted that, unlike the national standardized rates, the FY 2009 Puerto Rico-specific standardized amount was not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs. Therefore, for FY 2010, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific standardized amount by −1.1 percent in FY 2010 to account for the FY 2008 documentation and coding changes that are not due to changes in real case-mix and to leave that adjustment in place for subsequent fiscal years.

Consistent with our approach for determining the national average standardized amounts and hospital-specific rates of SCHs and MDHs discussed above, after consideration of the public comments we received on our analysis and proposals presented in the FY 2010 IPPS proposed rule, for FY 2010, we also postponed adoption of a documentation and coding adjustment to the Puerto Rico-specific rates until a full analysis of FY 2009 case-mix changes can be completed. Accordingly, in the FY 2010 IPPS final rule, for FY 2010, we did not apply a documentation and coding adjustment to the Puerto Rico-specific rates.

As we have noted above, similar to SCHs and MDHs, hospitals in Puerto Rico use the same DRG system as all other hospitals and we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals.

As we have discussed in section II.D. of the preamble of this proposed rule, our best estimate, based on the most recently available data, is that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to Puerto Rico hospitals to account for documentation and coding changes. Therefore, the entire −2.4 percent adjustment remains to be implemented. In order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals but to take into consideration the fact that the cumulative impact was smaller in Puerto Rico hospitals, we are therefore proposing an adjustment of −2.4 percent in FY 2011 to Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount, which are proposing to adjust as described above. Consequently, the overall reduction to rates for Puerto Rico hospitals to account for the documentation and coding changes will be slightly less than the reduction for IPPS hospitals based on 100 percent of the national standardized amount. We note that this proposed −2.4 percent prospective adjustment would eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity between hospitals paid on the basis of different prospective rates.

e. Proposed Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier "fixed-loss cost threshold." To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2011 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. We note that the statute requires outlier payments to be not less than 5 percent nor more than 6 percent of total "operating DRG payments" (which does not include IME and DSH payments) plus outlier payments. When setting the outlier threshold, we compute the 5.1 percent target by dividing the total operating outlier payments by the total operating DRG payments plus outlier payments. We do not include any other payments such as IME and DSH within the outlier target amount. Therefore, it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation. Section

1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage.*

(1) Proposed FY 2011 Outlier Fixed-Loss Cost Threshold

For FY 2011, we are proposing to continue to use the same methodology used for FY 2009 (73 FR 48763 through 48766) to calculate the outlier threshold. Similar to the methodology used in the FY 2009 IPPS final rule, for FY 2011, we are proposing to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2011 outlier threshold, we simulated payments by applying the proposed FY 2011 rates and policies using cases from the FY 2009 MedPAR files. Therefore, in order to determine the proposed FY 2011 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2009 to FY 2011.

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

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2008 in combination with the first quarter of FY 2008 (July 1, 2008 through December 31, 2008) to the last quarter of FY 2009 in combination with the first quarter of FY 2010 (July 1, 2009 through December 31, 2009). This rate of change was 5.16 percent (1.0516) or 10.59 percent (1.1059) over 2 years.

As we have done in the past, we established the proposed FY 2011 outlier threshold using hospital CCRs from the December 2009 update to the Provider-Specific File (PSF)—the most recent available data at the time of this proposed rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 IPPS final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2011, we are proposing to continue to use the same methodology to calculate the CCR adjustment by using the FY 2009 operating cost per discharge increase in combination with the actual FY 2009 operating market basket percentage increase determined by IHS Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. (We note that the FY 2009 actual (otherwise referred to as "final") operating market basket percentage increase reflects historical data, whereas the published FY 2009 operating market basket update factor was based on IHS Global Insight, Inc.'s 2008 second quarter forecast with historical data through the first quarter of 2008. We also note that while the FY 2009 published operating market basket update was based on the FY 2002-based IPPS market basket, the actual or "final" market basket percentage increase is based on the FY 2006-based IPPS market basket. Similarly, the FY 2009 published capital market basket upate factor was based on the FY 2002-based capital market basket and the actual or "final" capital market basket percentage increase is based on the FY 2006-based capital market basket.) By using the operating market basket percentage increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2011, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2007 to FY 2008 (1.0513) from the cost report and dividing it by the final operating market basket percentage increase from FY 2008 (1.04). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the nonprice factors in the cost increase (for example, quantity and changes in the mix of goods and services). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the operating market basket percentage increase and the increase in cost per case from the cost report (the FY 2005 to FY 2006 percentage increase of operating costs per discharge of 1.0577 divided by the FY 2006 final operating market basket percentage increase of 1.04, the FY 2006 to FY 2007 percentage increase of operating costs per discharge of 1.0466 divided by FY 2007 final operating market basket percentage increase of 1.0360). For FY 2011, we averaged the differentials calculated for FY 2006, FY 2007, and FY 2008, which resulted in a mean ratio of 1.0127. We multiplied the 3-year average of 1.0127 by the FY 2009 final operating market basket percentage increase of 1.027, which resulted in an operating cost inflation factor of 4.00 percent or 1.0400. We then divided the operating cost inflation factor by the 1-year average change in charges (1.0515) and applied an adjustment factor of 0.989016 to the operating CCRs from the PSF (calculation performed on unrounded numbers).

As stated in the FY 2009 IPPS final rule (73 FR 48763), we continue to believe it is appropriate to apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9 months for a fiscal intermediary or MAC to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average "age" of hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2009 is approximately 1 year. Therefore, as stated above, we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2007 to FY 2008 (1.0800) from the cost report and dividing it by the final capital market basket percentage increase from FY 2008 (1.015). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket percentage increase and the increase in cost per case from the cost report (the FY 2005 to FY 2006 percentage increase of capital costs per discharge of 1.0464 divided by the FY 2006 final capital market basket percentage increase of 1.011, the FY 2006 to FY 2007 percentage increase of capital costs per discharge of 1.0512 divided by the FY 2007 final capital market basket percentage increase of 1.012). For FY 2011, we averaged the differentials calculated for FY 2006, FY 2007, and FY 2008, which resulted in a mean ratio of 1.0459. We multiplied the 3-year average of 1.0459 by the FY 2009 final capital market basket percentage increase of 1.014, which resulted in a

capital cost inflation factor of 6.06 percent or 1.0606. We then divided the capital cost inflation factor by the 1-year average change in charges (1.0516) and applied an adjustment factor of 1.008534 to the capital CCRs from the PSF (calculation performed on unrounded numbers). We are proposing to use the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2011, we applied the proposed FY 2011 rates and policies using cases from the FY 2009 MedPAR files in calculating the proposed outlier threshold. In FY 2010, for purposes of estimating the proposed outlier threshold, we took into account the remaining projected case-mix growth when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2010. As explained in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44008), for the FY 2010 analysis, we inflated the FY 2008 claims data by an additional 1.6 percent for the additional case-mix growth projected to have occurred since FY 2008. If we did not take into account the remaining 1.6 percent projected case-mix growth, our estimate of total FY 2010 payments would have been too low, and, as a result, the FY 2010 final outlier threshold would have been too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments. For this proposed rule, we are using the FY 2009 claims data to calculate the FY 2011 proposed outlier threshold. Our estimate of the cumulative effect of changes in documentation and coding due to the adoption of the MS–DRGs through FY 2009 is 5.4 percent, which is already included within the claims data (FY 2009 MedPAR files) used to calculate the proposed FY 2011 outlier threshold. Furthermore, we currently estimate that there will be no continued changes in documentation and coding in FYs 2010 and 2011. Therefore, the cumulative effect of documentation and coding that has occurred is already reflected within the FY 2009 MedPAR claims data, and we do not believe there is any need to inflate FY 2009 claims data for any additional case-mix growth projected to have occurred since FY 2009.

Using this methodology, we are proposing an outlier fixed-loss cost threshold for FY 2011 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $23,970.

As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2011 outlier payments, we are not proposing to make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule (68 FR 34494), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are proposing not to make any assumptions about the effects of reconciliation on the outlier threshold calculation.

(2) Other Proposed Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2011 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.8 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are proposing to reduce the FY 2011 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that would be applied to the standardized amount for the proposed FY 2011 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.942415
Puerto Rico	0.951686	0.924977

We are proposing to apply the outlier adjustment factors to the proposed FY 2011 rates after removing the effects of the FY 2010 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, for hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.176 or capital CCRs greater than 0.154, or hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations), we still use statewide average CCRs to determine whether a hospital qualifies for outlier payments.[15] Table 8A in this Addendum contains the proposed statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2010, these statewide average ratios would replace the ratios published in the IPPS final rule for FY 2010 (74 FR 44159). Table 8B in this Addendum contains the proposed comparable statewide average capital CCRs. Again, the proposed CCRs in Tables 8A and 8B would be used during FY 2011 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. Table 8C contains the proposed statewide average total

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

CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their fiscal intermediary or MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement, thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and CCRs, we refer readers to CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2009 and FY 2010 Outlier Payments

In the FY 2010 IPPS final rule (74 FR 44012), we stated that, based on available data, we estimated that actual FY 2009 outlier payments would be approximately 5.4 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2008 MedPAR file (discharge data for FY 2008 claims). That is, the estimate of actual outlier payments did not reflect actual FY 2009 claims, but instead reflected the application of FY 2009 rates and policies to available FY 2008 claims.

Our current estimate, using available FY 2009 claims data, is that actual outlier payments for FY 2009 were approximately 5.3 percent of actual total DRG payments. Thus, the data indicate that, for FY 2009, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2009. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2009 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2010 will be approximately 4.7 percent of actual total DRG payments, approximately 0.4 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2010. This estimate is based on simulations using the FY 2009 MedPAR file (discharge data for FY 2009 claims). We used these data to calculate an estimate of the actual outlier percentage for FY 2010 by applying FY 2010 rates and policies, including an outlier threshold of $23,140 to available FY 2009 claims.

5. Proposed FY 2011 Standardized Amount

The proposed adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are proposing to apply to all hospitals, except hospitals located in Puerto Rico, for FY 2011. The proposed Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The proposed amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the labor-related share of 68.8 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indices are less than or equal to 1.0000.

In addition, Tables 1A and 1B include proposed standardized amounts reflecting the proposed full 2.4 percent update for FY 2011, and the proposed standardized amounts reflecting the 2.0 percentage point reduction to the update (a 0.4 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this proposed amount is set forth in Table 1A). The proposed labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2011 are set forth in Table 1C of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico specific standardized amount is the proposed labor-related share of 62.1 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the proposed changes from the FY 2010 national standardized amount. The second column shows the proposed changes from the FY 2010 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (2.4 percent). The third column shows the proposed changes for hospitals receiving the reduced update (0.4 percent). The first row of the table shows the proposed updated (through FY 2010) average standardized amount after restoring the FY 2010 offsets for outlier payments, demonstration budget neutrality and the geographic reclassification budget neutrality. The DRG reclassification and recalibration wage index budget neutrality factors are cumulative. Therefore, the FY 2010 factor is not removed from this table. Additionally, the documentation and coding adjustments for FY 2008 and FY 2009 are cumulative. Therefore, the FY 2008 and FY 2009 adjustment factors are not removed from this table. We also have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2010 STANDARDIZED AMOUNTS TO THE PROPOSED FY 2011 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE

	Full Update (2.4 percent); Wage index is greater than 1.0000	Full Update (2.4 percent); Wage index is less than or equal to 1.0000	Reduced Update (0.4 percent); Wage index is greater than 1.0000	Reduced Update (0.4 percent); Wage index is less than or equal to 1.0000
FY 2010 Base Rate, after removing geographic reclassification budget neutrality, demonstration budget neutrality, cumulative FY 2008 and FY 2009 documentation and coding adjustment and outlier offset (based on the labor-related share percentage for FY 2010)	Labor: $3,879.09 Nonlabor: $1,759.12	Labor: $3,459.69 Nonlabor: $2,142.52	Labor: $3,879.09 Nonlabor: $1,759.12	Labor: $3,459.69 Nonlabor: $2,142.52
Proposed FY 2011 Update Factor	1.024	1.024	1.004	1.004
Proposed FY 2011 DRG Recalibration and Wage Index Budget Neutrality Factor	0.996963	0.996963	0.996963	0.996963
Proposed FY 2011 Reclassification Budget Neutrality Factor	0.991756	0.991756	0.991756	0.991756
Proposed FY 2011 Outlier Factor	0.948999	0.948999	0.948999	0.948999
Proposed Cumulative Documentation and Coding Adjustment	0.957	0.957	0.957	0.957
Proposed Rate for FY 2011	Labor: $3,566.91 Nonlabor: $1,617.55	Labor: $3,214.37 Nonlabor:$1,970.09	Labor: $3,497.24 Nonlabor: $1,585.96	Labor: $3,151.58 Nonlabor: $1,931.62

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national standardized amount (as set forth in Table 1A of this Addendum). The labor-related and nonlabor-related portions of the proposed national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the proposed Puerto Rico standardized amount is 62.1 percent, or 62 percent, depending on which results in higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Proposed Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2011. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Proposed Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble of this proposed rule, we discuss the data and methodology for the proposed FY 2011 wage index.

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

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area

wages described above. For FY 2011, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are the same as the factors currently in use under the IPPS for FY 2010. In addition, we are proposing that if OPM releases revised COLA factors after publication of this proposed rule, we would use the revised factors for the development of IPPS payments for FY 2011 and publish those revised COLA factors in the final rule.

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

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

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

C. Proposed MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this proposed rule, we have developed proposed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the proposed relative weights that we would apply to discharges occurring in FY 2011. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates

General Formula for Calculation of the Proposed Prospective Payment Rates for FY 2011

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2011 equals the Federal rate.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2011 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2011 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. For MDHs, the updated hospital-specific rate is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever yields the greatest aggregate payment.

The prospective payment rate for hospitals located in Puerto Rico for FY 2011 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 would be increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

As discussed previously, currently MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge or the FY 2006 costs per discharge, and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment period (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section III. of this Addendum. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2010.

b. Updating the FY 1982, FY 1987, FY 1996, FY 2002, and FY 2006 Hospital-Specific Rates for FY 2011

We are proposing to increase the hospital-specific rates by 2.4 percent (the hospital market basket percentage increase) for FY 2011 for those SCHs and MDHs that submit qualifying quality data and by 0.4 percent for SCHs and MDHs that fail to submit qualifying quality data. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2011, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percentage points for hospitals that fail to submit qualifying quality data. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided for under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2011, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percentage points for hospitals that fail to submit qualifying quality data.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 2010, and Before October 1, 2011

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (Table 1C of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate would then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2011

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2011, which would be effective for discharges occurring on or after October 1, 2010.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except "new" hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the respective fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital Federal rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital Federal rate made in FY 1996 as a result of the revised policy for paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which required that, for discharges occurring on or after October 1, 1997, the budget neutrality adjustment factor in effect as of September 30, 1995, be applied to the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate. That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was effective from October 1, 1997 through September 30, 2002, making the total reduction 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), the 2.1 percent reduction was restored to the unadjusted capital payment rates effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related

costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we discontinued use of the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for blended payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals located in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals located in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the national capital Federal rate.

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

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

In the correction notice to the FY 2010 IPPS/RY 2010 LTCH PPS final rule published on October 7, 2009 (74 FR 51499), we established the final capital Federal rate of $429.26 for FY 2010. In the discussion that follows, we explain the factors that we are proposing to use to determine the capital Federal rate for FY 2011. In particular, we explain why the proposed FY 2011 capital Federal rate would decrease approximately 1.9 percent, compared to the FY 2010 capital Federal rate. As discussed in the impact analysis, we estimate capital payments per discharge would decrease 0.2 percent during that same period. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

We note that on March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the providers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to implement those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this section do not reflect the new legislation. We plan to issue separate rulemaking documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we adjust the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2011 under that framework is 1.5 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2009 DRG reclassification and recalibration, and a forecast error correction of 0.3 percent. As discussed below in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2011 CIPI projection in that same section of this Addendum. We note, as discussed in section VI.E.1. of the preamble of this proposed rule, we are proposing to apply a −2.9 percent adjustment to the capital rate in FY 2011 to account for the cumulative effect of changes in documentation and coding under the MS–DRGs that do not correspond to changes in real increases in patients' severity of illness. Below we describe the policy adjustments that we are proposing to apply in the update framework for FY 2011.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes ("real" case-mix change);
- Changes in hospital documentation and coding of patient records result in higher weight DRG assignments ("coding effects"); and
- The annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect").

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in documentation and coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent any increase in case-mix resulting from changes in documentation and coding due to the adoption of the MS–DRGs, for FY 2011, we are projecting a 1.0 percent total increase in the case-mix index. We estimated that the real case-mix increase will also equal 1.0 percent for FY 2011. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the proposed net adjustment for case-mix change in FY 2011 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2009 DRG reclassification and recalibration as part of our proposed update for FY 2011. To adjust for reclassification and recalibration effects, under our historical methodology, we run the FY 2009 cases through the FY 2008 GROUPER and through the FY 2009 GROUPER. The resulting ratio of the case-mix indices should equate to 1.0. If not, under our historical methodology, in the update framework for FY 2011, we would make an adjustment to adjust for the reclassification and recalibration effects in FY 2009. As discussed in detail in section II.B. of the preamble of this proposed rule, however, when we adopted the MS–DRGs beginning in FY 2008 to better recognize severity of illness in Medicare payment rates, we also recognized that changes in documentation and coding could potentially lead to increases in aggregate payments without a corresponding increase in patients' severity of illness (that is, increased case-mix index other than real case-mix index increase). To maintain budget neutrality for the adoption of the MS–DRGs, as discussed in greater detail in section V.E. of the preamble of this proposed rule, we are proposing to make an adjustment to the proposed capital Federal rate in FY 2011 based on actuarial estimates of the cumulative effects of documentation and coding changes that occurred in FYs 2008 and 2009 (based on FYs 2008 and 2009 claims data). Therefore, we are not adjusting for reclassification and recalibration effects from FY 2009 in the update framework for FY 2011 because it is already accounted for in the proposed documentation and coding adjustment to the capital Federal rates for FY 2011. Consequently, we are proposing a 0.0 percent adjustment for DRG reclassification and recalibration in the proposed FY 2011 update framework.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of 0.3 percentage point was calculated for the FY 2011 update. That is, current historical data indicate that the forecasted FY 2009 CIPI (1.4 percent) used in calculating the FY 2009 update factor slightly understated the actual realized price increases (1.7 percent) by 0.3 percentage point. This is due to the prices associated with both the depreciation and interest cost categories growing faster than anticipated. Historically, when the estimation of the change in the CIPI is greater than 0.25 percentage points, it is reflected in the update recommended under this framework. Therefore, we are proposing to make a 0.3 percent adjustment for forecast error in the update for FY 2011.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. Historically, we have calculated this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services. Our intensity measure is based on a 5-year average.

Historically, we have calculated case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CIPI for hospital and related services) and changes in real case-mix. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (*Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988* by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on

total change, but was usually a fairly steady increase of 1.0 to 1.5 percent per year. However, we used 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed as a result of hospitals attempting to maximize outlier payments, while lessening costs, and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments. For FYs 2006 through 2010, we continued to apply a 0.0 percent adjustment for intensity in the capital update framework.

In an effort to further refine the intensity adjustment and more accurately reflect allowable changes in hospital intensity, we are proposing to use changes in hospital *costs* per discharge over a 5-year average rather than changes in hospital charges, which have been the basis of the intensity adjustment in prior years. The unique nature of capital—how and when it is purchased, its longevity, and how it is financed—creates a greater degree of variance in capital cost among hospitals than does operating cost. We believe that using changes in capital costs per discharge as the basis for the intensity adjustment in lieu of changes in charges will decrease some of the variability of this adjustment. A case in point is the charge data over much of the last decade— the annual change in hospital charges has fluctuated erratically from as little as 3 percent to as large as 16 percent. As we have discussed for several years in past rulemaking, we believe the effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule were the main cause of the variability and large annual increases in hospital charges for much of the past decade. However, even after the outlier policy was implemented, we continued to see evidence of these charge practices in the data, as it may have taken hospitals some time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the charge data for much of the past decade was skewed because if hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, we would expect hospitals' case-mix to increase proportionally, and it did not.

Therefore, in this proposed rule, for the reasons discussed above, we believe it would be more appropriate to use our intensity adjustment based on the change in capital cost per discharge. To determine the proposed intensity adjustment for FY 2011, we have replaced charge data with capital cost per discharge data. As expected, there are significantly smaller increases in cost per discharge over this time period and less fluctuation from year to year. As we did when using charge data, we are basing the intensity measure on a 5-year average. Therefore, the proposed intensity measure for FY 2011 is based on an average of cost per discharge data from the 5-year period beginning with FY 2004 and extending through FY 2008. Based on these data, we estimate that case-mix constant intensity declined during FYs 2004 through 2008. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Because we estimate intensity declined during that 5-year period, we believe that it is appropriate to continue apply a zero intensity adjustment for FY 2011. Therefore, we are proposing to make a 0.0 percent adjustment for intensity in the update for FY 2011.

Above, we described the basis of the components used to develop the proposed 1.5 percent capital update factor under the capital update framework for FY 2011 as shown in the table below.

CMS FY 2011 PROPOSED UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index Intensity:	1.2
	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.2
Effect of FY 2009 Reclassification and Recalibration	0.0
Forecast Error Correction	0.3
Total Update	1.5

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2010 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2011. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2010, Section 2A.)

2. Proposed Outlier Payment Adjustment Factor

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

For FY 2010, we estimated that outlier payments for capital would equal 5.35 percent of inpatient capital-related payments based on the capital Federal rate in FY 2010. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs would equal 5.76 percent for inpatient capital-related payments based on the proposed capital Federal rate in FY 2011. Therefore, we are proposing to apply an outlier adjustment factor of 0.9424 in determining the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2011 would be higher than the percentage for FY 2010. This increase in capital outlier payments is primarily due to the estimated decrease in capital IPPS payments per discharge. That is, because capital payments per discharge are projected to be slightly lower in FY 2011 compared to FY 2010, as shown in Table III. in section VIII. of Appendix A

to this proposed rule, more cases would qualify for outlier payments.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2011 outlier adjustment of 0.9424 is a -0.54 percent change from the FY 2010 outlier adjustment of 0.9475. Therefore, the net change in the outlier adjustment to the proposed capital Federal rate for FY 2011 is 0.9946 (0.9424/0.9475). Thus, the proposed outlier adjustment decreases the proposed FY 2011 capital Federal rate by 0.54 percent compared with the FY 2010 outlier adjustment.

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

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

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

To determine the proposed factors for FY 2011, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2010 MS–DRG classifications and relative weights and the FY 2010 GAF to estimated aggregate capital Federal rate payments based on the FY 2010 MS–DRG classifications and relative weights and the proposed FY 2011 GAFs. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0007 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9907, yielding an adjustment of 0.9915, through FY 2011 (calculated with unrounded numbers). For the Puerto Rico GAFs, we are proposing to apply an incremental budget neutrality adjustment of 1.0004 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9969, yielding a cumulative adjustment of 0.9973 through FY 2011.

We then compared estimated aggregate capital Federal rate payments based on the FY 2010 DRG relative weights and the proposed FY 2011 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the proposed FY 2011 MS–DRG classifications and relative weights and the proposed FY 2011 GAFs. The proposed incremental adjustment for DRG classifications and proposed changes in relative weights is 0.9992 both nationally and for Puerto Rico. The proposed cumulative adjustments for MS–DRG classifications and proposed changes in relative weights and for proposed changes in the GAFs through FY 2011 are 0.9907 nationally and 0.9965 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	—	—	—	1.00000	—	—	—	—
1993	—	—	0.99800	0.99800	—	—	—	—
1994	—	—	1.00531	1.00330	—	—	—	—
1995	—	—	0.99980	1.00310	—	—	—	—
1996	—	—	0.99940	1.00250	—	—	—	—
1997	—	—	0.99873	1.00123	—	—	—	—
1998	—	—	0.99892	1.00015	—	—	—	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
2009[15]	1.00206	0.99945	1.00150	0.99170	1.00097	0.99945	1.00041	0.99595
2010[16]	0.99950	0.99953	0.99902	0.99073	1.00141	0.99953	1.00094	0.99688
2011[17]	1.00074	0.99922	0.99997	0.99070	1.00036	0.99922	0.99959	0.99647

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2]Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11]Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13]Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14]Incremental factors are applied to average of the cumulative factors for 2005.
[15]Final factors for FY 2009, including the implementation of section 124 of Pub. L. 110-275, which affects wage indices and GAFs for FY 2009,
[16]Final factors for FY 2010.
[17]Proposed factors for FY 2011

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The methodology used to determine the recalibration and geographic adjustment factor (DRG/GAF) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital IPPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined

separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

For FY 2010, we calculated a final GAF/DRG budget neutrality factor of 0.9990 (74 FR 44019). For FY 2011, we are proposing to establish a GAF/DRG budget neutrality factor of 1.0000. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the proposed adjustment from FY 2010 to FY 2011 is 1.0000. The cumulative change in the proposed capital Federal rate due to this adjustment is 0.9907 (the product of the incremental factors for FYs 1995 though 2010 and the proposed incremental factor of 1.0000 for FY 2011). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the cumulative adjustment of 0.9907 for FY 2011.)

The proposed factor accounts for the proposed MS–DRG reclassifications and recalibration and for proposed changes in the GAFs. It also incorporates the effects on the proposed GAFs of FY 2011 geographic reclassification decisions made by the MGCRB compared to FY 2010 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) of our regulations requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the proposed FY 2011 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments are made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the proposed exceptions adjustment used in calculating the FY 2011 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets the following criteria: (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries and MACs, six hospitals have qualified for special exceptions payments under § 412.348(g). One of these hospitals closed in May 2005. Because we have cost reports ending in FY 2008 for four of these five hospitals, we calculated the adjustment based on actual cost experience. (We note that the one hospital for which we do not have FY 2008 cost report data has had zero special exception payments for all available past cost reports. Consequently, we expect that this hospital would not have any special exceptions payments in FY 2008, and the lack of this hospital's FY 2008 cost report data would not distort the calculation of the adjustment.) Using data from cost reports ending in FY 2008 from the December 2009 update of the HCRIS data, we divided the capital special exceptions payment amounts for the four available hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2008, this ratio is rounded to 0.0003, and we are proposing to make an adjustment of 0.0003. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.03 percent for special exceptions payments for FY 2011. Therefore, the proposed exceptions adjustment factor is equal to 0.9997 (1 − 0.0003) to account for estimated special exceptions payments in FY 2011.

In the FY 2010 IPPS final rule (74 FR 44019), we estimated that total (special) exceptions payments for FY 2010 would equal 0.02 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9998 (1 − 0.0002) to determine the FY 2010 capital Federal rate. As we stated above, we are proposing to apply an exceptions payment adjustment factor of 0.9997 to the proposed capital Federal rate for FY 2011 based on our estimate that exceptions payments in FY 2011 would equal 0.03 percent of aggregate payments based on the proposed FY 2011 capital Federal rate. The proposed exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the proposed exceptions adjustment factor used in determining the proposed FY 2011 capital Federal rate is 0.9999 (0.9997/0.9998).

5. Proposed Capital Standard Federal Rate for FY 2011

For FY 2010, we established a final capital Federal rate of $429.26 (74 FR 51499). We are proposing to establish an update of 1.5 percent in determining the proposed FY 2011 capital Federal rate for all hospitals. However, as discussed in greater detail in section V.E. of the preamble of this proposed rule, under the statutory authority at section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing an additional 2.9 percent reduction to the national capital Federal payment rate in FY 2011. The proposed −2.9 percent adjustment is based on our actuary's analysis of the effect of changes in case-mix resulting from documentation and coding changes that do not reflect real changes in the case-mix in light of the adoption of MS–DRGs. Accordingly, we are proposing to apply a cumulative documentation and coding adjustment factor of 0.957 in determining the proposed FY 2011 capital Federal rate percent (that is, the

existing −0.6 percent adjustment in FY 2008 plus the −0.9 percent adjustment in FY 2009 plus the proposed additional −2.9 percent adjustment, computed as 1 divided by (1.006 × 1.009 × 1.029). (We note that we did not apply a documentation and coding adjustment to the capital Federal rate in FY 2010 (74 FR 43927).) As a result of the proposed 1.5 percent update and other proposed budget neutrality factors discussed above, we are proposing to establish a national capital Federal rate of $420.99 for FY 2011. The proposed national capital Federal rate for FY 2011 was calculated as follows:

- The proposed FY 2011 update factor is 1.015, that is, the update is 1.5 percent.
- The proposed FY 2011 budget neutrality adjustment factor that is applied to the proposed capital standard Federal payment rate for proposed changes in the MS–DRG classifications and relative weights and proposed changes in the GAFs is 1.0000.
- The proposed FY 2011 outlier adjustment factor is 0.9424.
- The proposed FY 2011 (special) exceptions payment adjustment factor is 0.9997.
- The proposed cumulative adjustment factor for FY 2011 applied to the national capital Federal rate for changes in documentation and coding under the MS–DRGs is 0.957.

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

We are providing the following chart that shows how each of the proposed factors and adjustments for FY 2011 affects the computation of the proposed FY 2011 national capital Federal rate in comparison to the FY 2010 national capital Federal rate. The proposed FY 2011 update factor has the effect of increasing the proposed capital Federal rate by 1.5 percent compared to the FY 2010 capital Federal rate. The proposed GAF/DRG budget neutrality factor of 1.000 has no net effect on the proposed capital Federal rate. The proposed FY 2011 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.54 percent compared to the FY 2010 capital Federal rate. The proposed FY 2011 exceptions payment adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.01 percent compared to the FY 2010 capital Federal rate. Furthermore, as shown in the chart below, the resulting cumulative adjustment for changes in documentation and coding that do not reflect real changes in patients' severity of illness (that is, the proposed cumulative adjustment factor of 0.957 has the net effect of decreasing the proposed FY 2011 national capital Federal rate by 2.8 percent as compared to the FY 2010 national capital Federal rate. (As discussed in section VI.E.1. of the preamble of this proposed rule, a cumulative adjustment of −1.5 percent (that is, the −0.6 percent in FY 2008 and −0.9 percent in FY 2009) or a cumulative adjustment factor of 0.985 has already been applied to the FY 2010 capital Federal rate for changes in documentation and coding that do not reflect real changes in patients' severity of illness. We did not apply any additional documentation and coding adjustment to the capital Federal rate in FY 2010). The combined effect of all the proposed changes would decrease the proposed national capital Federal rate by approximately 1.93 percent compared to the FY 2010 national capital Federal rate.

Comparison of Factors and Adjustments: FY 2010 Capital Federal Rate and Proposed FY 2011 Capital Federal Rate

	FY 2010	Proposed FY 2011	Change	Percent Change
Update Factor[1]	1.0120	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor[1]	0.9990	1.0000	1.0000	0.00
Outlier Adjustment Factor[2]	0.9475	0.9424	0.9946	-0.54
Exceptions Adjustment Factor[2]	0.9998	0.9997	0.9999	-0.01
MS-DRG Documentation and Coding Adjustment Factor	0.9850[3]	0.9570[4]	0.9716[5]	-2.84
Capital Federal Rate	$429.26	$420.99	0.9807	-1.93

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2010 to FY 2011 resulting from the application of the proposed 1.000 GAF/DRG budget neutrality factor for FY 2011 is a net change of 1.00 (zero percent).

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the proposed net change resulting from the application of the proposed FY 2011 outlier adjustment factor is 0.9475/0.9424, or 0.9946.

[3] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, and no additional reduction in FY 2010.

[4] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, no additional reduction in FY 2010 and the proposed -2.9 percent reduction in FY 2011.

[5] The change is measured from the FY 2009 cumulative factor of 0.9850.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

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

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

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The proposed national GAF budget neutrality factor is 1.0004 and the proposed DRG adjustment is 0.9992, for a combined cumulative adjustment of 0.9965.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2010, the special capital rate for hospitals located in Puerto Rico was $203.56 (74 FR 51499). Consistent with our development of the FY 2010 Puerto Rico-specific operating standardized amount, we have not applied the −0.6 percent adjustment in FY 2008 or the −0.9 percent documentation and coding adjustment in FY 2009 (that is, the cumulative −1.5 percent adjustment) that was applied to the national capital Federal rate to the Puerto Rico-specific capital rate. However, we noted in the FY 2009 IPPS final rule (73 FR 48449 through 48550) that we may propose to apply such an adjustment to the Puerto Rico operating and capital rates in the future.

As noted above and discussed in greater detail in section V.E.4. of the preamble of this proposed rule, consistent with our development of the Puerto Rico-specific operating standardized amount, we are proposing to apply a −2.4 percent adjustment to account for changes in documentation and coding that resulted from the adoption of the MS–DRGs in determining the proposed FY 2011 Puerto Rico-specific capital rate. With the changes we are proposing to make to the other factors used to determine the capital rate, the proposed FY 2011 special capital rate for hospitals in Puerto Rico is $199.43.

B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2011

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2011.

For purposes of calculating payments for each discharge during FY 2011, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in Alaska and Hawaii) x (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2011 are in section II.A. of this Addendum. For FY 2011, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $23,970.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) up through the 10th year beyond the end of the capital transition period if it meets the following criteria: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals. We note that this was a 10-year provision. Therefore, FY 2012 is the final year hospitals will be eligible for the special exceptions payment.

Currently, as provided in § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a

fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. In the FY 2010 IPPS final rule (74 FR44021), we rebased and revised the CIPI to a FY 2006 base year to reflect the more current structure of capital costs in hospitals. A complete discussion of this rebasing is provided in section IV. of the preamble of that final rule.

2. Forecast of the CIPI for FY 2011

Based on the latest forecast by IHS Global Insight, Inc. (first quarter of 2010), we are forecasting the FY 2006-based CIPI to increase 1.2 percent in FY 2011. This reflects a projected 1.8 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 1.9 percent increase in other capital expense prices in FY 2011, partially offset by 1.9 percent decline in vintage-weighted interest expenses in FY 2011. The weighted average of these three factors produces the 1.2 percent increase for the FY 2006-based CIPI as a whole in FY 2011.

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

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. The updated target amount for that period was multiplied by the Medicare discharges during that period and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payments for services furnished in children's hospitals and cancer hospitals that are excluded from the IPPS continue to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

We are proposing that the FY 2011 rate-of-increase percentage for updating the target amounts for cancer and children's hospitals and RNHCIs be the estimated percentage increase in the FY 2011 IPPS operating market basket, estimated to be 2.4 percent, using the most recent data available based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter. (We are proposing to use more recent data when determining the estimated percentage increase for the FY 2011 IPPS operating market basket for the final rule, to the extent these data are available.)

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

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VII. of the preamble and section V. of the Addendum to this proposed rule for the proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2011. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Proposed Changes to the Payment Rates for the LTCH PPS for FY 2011

A. Proposed LTCH PPS Standard Federal Rate for FY 2011

1. Background

In section VII. of the preamble of this proposed rule, we discuss our proposed changes to the payment rates, factors, and specific policies under the LTCH PPS for FY 2011. We note that on March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

At § 412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established that policy of annually updating the standard Federal rate because, at that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after the initial implementation of the LTCH PPS in FY 2003. Under § 412.523(c)(3)(ii), for RYs 2004 through 2006, the annual update to the LTCH PPS standard Federal rate was equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services.

In determining the annual update to the standard Federal rate for RY 2007, based on our ongoing monitoring activity, we believed that, rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor, it was appropriate to adjust the standard Federal rate to account for the changes in documentation and coding practices in a prior period that were unrelated to patient severity of illness (71 FR 27818). Accordingly, we established regulations at § 412.523(c)(3)(iii) to specify that the update to the standard Federal rate for RY 2007 is zero percent based on the most recent estimate of the LTCH PPS market basket at the time, offset by an adjustment to account for changes in case-mix in prior periods due to changes in documentation and coding that were unrelated to patient severity of illness in FY 2004. For RYs 2008 through 2010, we also considered changes in documentation and coding practices that were unrelated to patient severity of illness in establishing the annual update to the standard Federal rate as set forth in the regulations at §§ 412.523(c)(3)(iv) through (c)(3)(vi). (We note that section 114(e)(1) of Public Law 110–173 provided that the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. In addition, section 114(e)(2) of Public Law 110–173 specified that the revised standard Federal rate provided for under section 114(e)(1) "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008," effectively resulting in a delay of the application of the updated standard Federal rate for RY 2007 established in the RY 2008 LTCH PPS final rule (72 FR 26890).) Consistent with our historical practice, in the RY 2010 LTCH PPS final rule, we established an annual update to the standard Federal rate for RY 2010 based on the most recent estimate of the increase in the LTCH PPS market basket at that time (2.5 percent and an adjustment of −0.5 percent to account for the increase in case-mix in a prior period (FY 2007) due to changes in documentation and coding practices unrelated to an increase in patient severity of illness (74 FR 44022)). Accordingly, we established regulations at § 412.523(c)(3)(vi) to specify that the update to the standard Federal rate for RY 2010 is 2.0 percent.

2. Development of the Proposed FY 2011 LTCH PPS Standard Federal Rate

While we continue to believe that an update to the LTCH PPS standard Federal rate should be based on the most recent estimate of the increase in the LTCH PPS market basket, we also believe it is appropriate that the standard Federal rate be offset by an adjustment to account for any changes in documentation and coding practices that do not reflect increased patient severity of illness. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients. Furthermore, as we discussed most recently in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022), we did not establish a case-mix budget neutrality factor (that is, a documentation and coding adjustment for changes in case-mix that are not due to changes in patient severity of illness) for the adoption of the severity adjusted MS–LTC–DRG patient classification system. Rather, we noted that, consistent with past LTCH payment policy, we would continue to monitor LTCH data and we could propose to make adjustments when updating the LTCH PPS standard Federal rate in the future to account for changes in documentation and coding that do not reflect any real changes in case-mix during these years that we are implementing MS–LTC–DRGs. As noted above, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we applied a −0.5 percent adjustment to account for the effect of changes in documentation and coding on the increase in case-mix in FY 2007. Although we proposed a −1.3 percent adjustment to account for the effect of changes in documentation and coding on the increase in case-mix in FY 2008, in the final rule after consideration of public comments and consistent with IPPS policy, we delayed the application of that adjustment (74 FR 43970 through 43972).

For FY 2011, for this proposed rule as discussed in greater detail in section VII.C.3. of the preamble of this proposed rule, we performed a CMI analysis using the most recent available LTCH claims data (FY 2009) under both the current MS–LTC–DRG and the former CMS LTC–DRG patient classification systems. Based on this evaluation, we determined that there was a cumulative increase in LTCH CMI of 2.5 percent due to changes in documentation and coding that did not reflect real changes in patient severity of illness for LTCH discharges occurring in FY 2008 and FY 2009. At this time, the most recent estimate of the increase in the proposed LTCH PPS market basket (that is, the FY 2002-based RPL market basket) for FY 2011 is 2.4 percent, as discussed in section VII.B.2. of the preamble of this proposed rule. Consistent with our historical practice, in this proposed rule, we are proposing to update the LTCH PPS standard Federal rate for FY 2011 based on the full proposed LTCH PPS market basket increase estimate of 2.4 percent and an adjustment to account for the increase in case-mix in a prior period (FYs 2008 and 2009) that resulted from changes in documentation and coding practices of −2.5 percent. The proposed update factor to the standard Federal rate for FY 2011 is −0.1 percent (that is, we are proposing to apply a factor of 0.999 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.024×1 divided by 1.025 = 0.999 or −0.1 percent). Therefore, in this proposed rule, under the broad authority conferred upon the Secretary under the BBRA and the BIPA to determine appropriate updates under the LTCH PPS, we are proposing to amend § 412.523 to add a new paragraph (c)(3)(vii) to specify that the standard Federal rate for discharges occurring on or after October 1, 2010, through September 30, 2011, is the standard Federal rate for the previous rate year updated by −0.1 percent. In determining the proposed standard Federal rate for FY 2011, we are applying the proposed 0.999 update factor to the RY 2010 Federal rate of $39,896.65 (as established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022)). Consequently, the proposed standard Federal rate for FY 2011 is $39,856.75. We also are proposing that if more recent data become available, we would use those data, if appropriate, to determine the update to the standard Federal rate for FY 2011 in the final rule, and, thus, the standard Federal rate update specified in the proposed regulation text at § 412.523(c)(3)(vii) could change accordingly.

B. Proposed Adjustment for Area Wage Levels Under the LTCH PPS for FY 2011

1. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS standard Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS standard Federal rate is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), when we implemented the LTCH PPS, we established a 5-year transition to the full wage index adjustment. The wage index adjustment was completely phased in for cost reporting periods beginning in FY 2007. Therefore, for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index values are the full (five-fifths) LTCH PPS wage index values calculated based on acute care hospital inpatient wage index data without taking into account geographic reclassification under section 1886(d)(8) and section 1886(d)(10) of the Act. For additional information on the phase-in of the wage index adjustment under the LTCH PPS, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56017 through 56019) and the RY 2008 LTCH PPS final rule (72 FR 26891).

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

a. Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels, the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. Specifically, the application of the LTCH PPS wage index adjustment at § 412.525(c) is made on the basis of the location of the LTCH in either an urban area or a rural area as defined in § 412.503. Currently under the LTCH PPS at § 412.503, an "urban area" is defined as a Metropolitan Statistical Area (which would include a metropolitan division, where applicable) as defined by the Executive OMB and a "rural area" is defined as any area outside of an urban area.

In the RY 2006 LTCH PPS final rule (70 FR 24184 through 24185), in regulations at § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005, based on the Executive OMB's CBSA designations, which are based on 2000 Census data. We made this revision because we believe that the CBSA-based labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. We note that these are the same CBSA-based designations implemented for acute care hospitals under the IPPS at § 412.64(b), effective October 1, 2004 (69 FR 49026 through 49034). (For further discussion of the CBSA-based labor market area (geographic classification) definitions currently used under the LTCH PPS, we refer readers to the RY 2006 LTCH PPS final rule (70 FR 24182 through 24191).) We have updated the LTCH PPS CBSA-based labor market area definitions annually since they were adopted for RY 2006 (73 FR 26812 through 26814, and 74 FR 44023 through 44204).

b. Update to the CBSA-Based Labor Market Area Titles and Principal Cities

On December 1, 2009, the Executive OMB announced changes to the principal cities and titles of a number of CBSAs and Metropolitan Divisions (OMB Bulletin No. 10–02). Under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we update our titles and definitions using the Executive OMB's bulletin. These changes are effective for discharges occurring on or after October 1, 2010.

Specifically, for FY 2011, the following CBSAs have new titles and new principal cities:

- San Marcos, TX qualifies as a new principal city of the Austin-Round Rock, TX CBSA. The new title is Austin-Round Rock-San Marcos, TX CBSA (CBSA Code 12420).
- Delano, CA qualifies as a new principal city of the Bakersfield, CA CBSA. The new title: Bakersfield-Delano, CA CBSA (CBSA Code 12540).
- Conroe, TX qualifies as a new principal city of the Houston-Sugar Land-Baytown, TX CBSA (CBSA Code 26420). The CBSA title is unchanged.
- North Port, FL qualifies as a new principal city of the Bradenton-Sarasota-Venice, FL CBSA (currently CBSA Code 14600). The new title is North Port-Bradenton-Sarasota, FL CBSA. The new code is CBSA 35840.
- Sanford, FL qualifies as a new principal city of the Orlando-Kissimmee, FL CBSA (CBSA Code 36740). The new title is Orlando-Kissimmee-Sanford, FL CBSA.
- Glendale, AZ qualifies as a new principal city of the Phoenix-Mesa-Scottsdale, AZ CBSA. The new title is Phoenix-Mesa-Glendale, AZ CBSA (CBSA Code 38060).
- Palm Desert, CA qualifies as a new principal city of the Riverside-San Bernardino-Ontario, CA CBSA (CBSA Code 40140). The CBSA title is unchanged.
- New Braunfels, TX qualifies as a new principal city of the San Antonio, TX CBSA. The new title is San Antonio-New Braunfels, TX CBSA (CBSA Code 41700).
- Auburn, WA qualifies as a new principal city of the Seattle-Tacoma-Bellevue, WA CBSA (CBSA Code 42644). The CBSA title is unchanged.

In addition, the following CBSAs have new titles as a result of changes to the order of principal cities based on population:

- Rockville, MD replaces Frederick, MD as the second most populous principal city in the Bethesda-Frederick-Rockville, MD Metropolitan Division. The new title is Bethesda-Rockville-Frederick, MD Metropolitan Division (CBSA Code 13644).
- Rock Hill, SC replaces Concord, NC as the third most populous principal city in the Charlotte-Gastonia-Concord, NC-SC CBSA. The new title is Charlotte-Gastonia-Rock Hill, NC-SC CBSA (CBSA Code 16740).
- Joliet, IL replaces Naperville, IL as the second most populous principal city in the Chicago-Naperville-Joliet, IL Metropolitan Division. The new title is Chicago-Joliet-Naperville, IL Metropolitan Division (CBSA Code 16974).
- Crestview, FL replaces Fort Walton Beach, FL as the most populous principal city in the Fort Walton Beach-Crestview-Destin, FL CBSA (currently CBSA Code 23020). The new title is Crestview-Fort Walton Beach-Destin, FL CBSA. The new code is 18880.
- Hillsboro, OR replaces Beaverton, OR as the third most populous principal city in the Portland-Vancouver-Beaverton, OR-WA CBSA. The new title is Portland-Vancouver-Hillsboro, OR-WA CBSA (CBSA Code 38900).
- Steubenville, OH replaces Weirton, WV as the most populous principal city in the Weirton-Steubenville, WV-OH CBSA (currently CBSA Code 48260). The new title is Steubenville-Weirton, OH-WV CBSA. The new CBSA code is 44600.

OMB Bulletin No. 10–02 is available on the OMB Web site at *http://www.whitehouse.gov/OMB*—go to "Bulletins" or "Statistical Programs and Standards."

The proposed FY 2011 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this proposed rule reflect the revisions to the CBSA-based labor market area titles and codes described above.

3. Proposed LTCH PPS Labor-Related Share

As noted above in this section, under the adjustment for difference in area wage levels at § 412.525(c), the labor-related share of a LTCH's PPS Federal prospective payment is adjusted by the applicable wage index for the labor market area in which the LTCH is located. The LTCH PPS labor-related share represents the sum of the labor-related portion of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs using the applicable LTCH PPS market basket. Currently, as established in the RY 2007 LTCH PPS final rule (71 FR 27829 through 27830), the LTCH PPS labor-related share is based on the relative importance of the labor-related share of operating costs and capital costs of the rehabilitation psychiatric long-term care (hospital) (RPL) market basket based on FY 2002 data, as they are the best available data that reflect the cost structure of LTCHs. For the past 3 years (RYs 2008, 2009, and 2010), we updated the LTCH PPS labor-related share annually based on the latest available data for the RPL market basket. For RY 2010, the labor-related share is 75.779 percent, as established in the RY 2010 LTCH PPS final rule (74 FR 43968 and 44024). (Additional background information on the historical development of the labor-related share under the LTCH PPS and the development of the RPL market basket can be found in the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817 and 27829 through 27830) and the RY 2010 LTCH PPS final rule (74 FR 43968).)

As discussed in greater detail in section VII.C.2.d. of the preamble of this proposed rule, we are proposing to use IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the proposed labor-related share for the LTCH PPS for FY 2011 that would be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data. The proposed labor-related share for FY 2011 would be the sum of the proposed FY 2011 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and FY 2011. The sum of the proposed relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) would be 71.537 percent and the labor-related share of capital costs would be 3.870 percent. Thus, the labor-related share that we are proposing to use for LTCH PPS in FY 2011 would be 75.407 percent (71.537 percent + 3.870 percent), as shown in the chart in section VII.C.2.d. of the preamble of this proposed rule.

Accordingly, under the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing to establish a labor-related share of 75.407 percent under the LTCH PPS for the FY 2011. Furthermore, consistent with our historical practice of using the best data available, we also are proposing that if more recent data are available to determine the labor-related share used under the LTCH PPS for FY 2011, we would use these data for determining the FY 2011 LTCH PPS labor-related share in the final rule.

4. Proposed LTCH PPS Wage Index for FY 2011

Historically, under the LTCH PPS, we have established LTCH PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act (67 FR 56019). The wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider.

In the RY 2010 LTCH PPS final rule (74 FR 44024 through 44026), we calculated the LTCH PPS wage indices using the same data used for the FY 2010 acute care hospital IPPS (that is, data from cost reporting periods beginning during FY 2006), without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act.

To determine the applicable wage index values under the LTCH PPS for FY 2011, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, consistent with our historical methodology, we are proposing to use wage data collected from cost reports submitted by IPPS hospitals for cost reporting periods beginning during FY 2007, without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act, because these data (FY 2007) are the most recent complete data available at this time. These are the same data used to compute the proposed FY 2011 acute care hospital inpatient wage index, as discussed in section III. of the preamble of this proposed rule. For our rationale for using IPPS hospital wage data as a proxy for determining the wage index values used under the LTCH PPS, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44024 through 44025).

The proposed FY 2011 LTCH PPS wage index values are computed consistent with the urban and rural geographic classifications (labor market areas) discussed above in section V.B.2. of the Addendum of this proposed rule and consistent with the pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). We also note that, as with the IPPS wage data, wage data for multicampus hospitals with campuses located in different labor market areas (CBSAs) are apportioned to each CBSA where the campus or campuses are located (discussed in section III.C. of the preamble of this proposed rule). We also would continue to use our existing policy for determining wage index values in areas where there are no IPPS wage data.

We established a methodology for determining a LTCH PPS wage index values for areas that have no IPPS wage data in the RY 2009 LTCH PPS final rule, and we are proposing to use this methodology for FY 2011. (We refer readers to 73 FR 26817 through 26818 for an explanation of and rationale for our policy.) Under this methodology, the LTCH PPS wage index value for urban CBSAs with no IPPS wage data is determined by using an average of all of the urban areas within the State. As was the case in RY 2010, there are currently no LTCHs located in labor areas without IPPS hospital wage data (or IPPS hospitals) for FY 2011. However, we calculate LTCH PPS wage index values for these areas using our established methodology in the event that, in the future, a LTCH should open in one of those areas.

Based on the current FY 2007 IPPS wage data that we are proposing to use to determine the proposed FY 2011 LTCH PPS wage index values, there are no IPPS wage data for the urban area of Anderson, SC (CBSA 11340) and Hinesville-Fort Stewart, GA (CBSA 25980). Consistent with the methodology discussed above, we calculated the proposed FY 2011 wage index value for CBSA 11340 as the average of the proposed wage index values for all of the other urban areas within the State of South Carolina (that

is, CBSAs 12260, 16700, 16740, 17900, 22500, 24860, 34820, 43900 and 44940) (reflected in Table 12A of the Addendum of this proposed rule). Similarly, for CBSA 25980 as the average of the proposed wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (reflected in Table 12A of the Addendum of this proposed rule). (As noted above, there are currently no LTCHs located in CBSA 11340 or CBSA 25980.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that urban areas without IPPS wage data will vary in the future.

For FY 2011, using our established methodology, we calculated a LTCH PPS wage index value for rural areas with no IPPS wage data using the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State (for an explanation of this policy, we refer readers to 73 FR 26818). For this purpose, we define "contiguous" as sharing a border.

Based on the FY 2007 IPPS wage data, there are no IPPS wage data for the rural area of Massachusetts (CBSA code 22). Consistent with the methodology discussed above, the proposed FY 2011 wage index value for rural Massachusetts is computed using the unweighted average of the wage indices from all of the CBSAs contiguous to the rural counties in that State. Specifically, the entire Massachusetts rural area consists of Dukes and Nantucket counties. The borders of Dukes and Nantucket counties are "contiguous" with Barnstable County, MA, and Bristol County, MA. Therefore, the proposed FY 2011 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the proposed FY 2011 wage indexes for Barnstable County and Bristol County (reflected in Tables 12A and 12B in the Addendum of this proposed rule). (There are currently no LTCHs located in rural Massachusetts.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that rural areas without IPPS wage data will vary in the future.

The proposed FY 2011 LTCH wage index values that would be applicable for LTCH discharges occurring on or after October 1, 2010, through September 30, 2011, are presented in Table 12A (for urban areas) and Table 12B (for rural areas) in the Addendum of this proposed rule.

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2010 LTCH PPS final rule (74 FR 44026) (under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS), for RY 2010, we applied a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table III of that same rule.

For FY 2011, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we are proposing to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the factors listed in the chart below because they are the most recent available data at this time. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are also proposed to be used under the IPPS effective October 1, 2010 (section II.B.2. of the Addendum of this proposed rule). We note that there has been no change in the COLA factors since the current factors were established in the RY 2010 LTCH PPS final rule. In addition, we are proposing that if OPM releases revised COLA factors before publication of the final rule, we would use the revised factors for the development of LTCH PPS payments for FY 2011 and publish those revised COLA factors in the final rule.

PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE LTCH PPS FOR FY 2011

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

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

1. Background

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

Under § 412.525(a) in the regulations (in conjunction with § 412.503), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the MS–LTC–DRG plus a fixed-loss amount. Specifically, in accordance with § 412.525(a)(3) (in conjunction with § 412.503), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold, which is the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold (MS–LTC–DRG payment plus the fixed-loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable

covered charge by the hospital's overall hospital cost-to-charge ratio (CCR).

Under the LTCH PPS, we determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent provider specific file (PSF) (or from the applicable statewide average CCR if a LTCH's CCR data are faulty or unavailable) are used to establish a fixed-loss threshold amount under the LTCH PPS.

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

The following is a discussion of CCRs that are used in determining payments for HCO and SSO cases under the LTCH PPS, at § 412.525(a) and § 412.529, respectively. Although this section is specific to HCO cases, because CCRs and the policies and methodologies pertaining to them are used in determining payments for both HCO and SSO cases (to determine the estimated cost of the case at § 412.529(d)(2)), we are discussing the determination of CCRs under the LTCH PPS for both of these types of cases simultaneously.

In determining both HCO payments (at § 412.525(a)) and SSO payments (at § 412.529), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(f)(4)(ii) for HCOs and SSOs, respectively. (We note that, in some instances, we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(f)(4)(iii), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(f)(4)(i).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single "overall" or "total" LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

b. LTCH Total CCR Ceiling

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, CCRs based on erroneous data should not be used to identify and make payments for outlier cases. Thus, under our established policy, generally, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44027), in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(f)(4)(iii)(B) for SSOs, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2009 update of the Provider Specific File (PSF), we established a total CCR ceiling of 1.232 under the LTCH PPS, effective October 1, 2009, through September 30, 2010. (For further detail on our current methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this proposed rule, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(f)(4)(iii)(B) for SSOs, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the December 2009 update of the PSF, we are proposing to establish a total CCR ceiling of 1.230 under the LTCH PPS that would be effective for discharges occurring on or after October 1, 2010, through September 30, 2011.

c. LTCH Statewide Average CCRs

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on "total" IPPS CCR data. Under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) and the SSO policy at § 412.529(f)(4)(iii), the fiscal intermediary may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In Table 8C of the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44160 through 44161), in accordance with the regulations at § 412.525(a)(4)(iv)(C) for HCOs and § 412.529(f)(4)(iii) for SSOs, using our established methodology for determining the LTCH statewide average CCRs, based on using the most recent complete IPPS total CCR data from the March 2009 update of the PSF, we established the LTCH PPS statewide average total CCRs for urban and rural hospitals effective for discharges occurring on or after October 1, 2009, through September 30, 2010. (For further detail on our current methodology for annually determining the LTCH statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this proposed rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the December 2009 update of the PSF, we are proposing to establish LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2010, through

September 30, 2011, in Table 8C of the Addendum to this proposed rule.

We also note that all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban; therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of December 2009. Therefore, for this proposed rule, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule.

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

d. Reconciliation of LTCH HCO and SSO Payments

We note that under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(D) and the LTCH PPS SSO policy at § 412.529(f)(4)(iv), the payments for HCO and SSO cases, respectively, are subject to reconciliation. Specifically, any reconciliation of outlier payments is based on the CCR that is calculated based on a ratio of CCRs computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For additional information, we refer readers to the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. Establishment of the Proposed LTCH PPS Fixed-Loss Amount for FY 2011

When we implemented the LTCH PPS, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the applicable CCR. Under § 412.525(a)(3) (in conjunction with § 412.503), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount).

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44028), we used our existing methodology to calculate the fixed-loss amount for RY 2010 in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Specifically, we used LTCH claims data from the March 2009 update of the FY 2008 MedPAR files and CCRs from the March 2009 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in RY 2010 because those data were the most recent complete LTCH data available at that time. In that same final rule, we established a fixed-loss amount of $18,425 for RY 2010.

In this proposed rule, we are proposing to continue to use our existing methodology to calculate the proposed fixed-loss amount for FY 2011 (based on updated data and the proposed rates and policies presented in this proposed rule) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. (For an explanation of our rationale for establishing an HCO payment "target" of 8 percent of total estimated LTCH payments, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) Consistent with our historical practice of using the best data available, in determining the proposed fixed-loss amount for FY 2011, we use the most recent available LTCH claims data and CCR data. Specifically, for this proposed rule, we used LTCH claims data from the December 2009 update of the FY 2009 MedPAR files and CCRs from the December 2009 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in FY 2011 because these data are the most recent complete LTCH data currently available. Consistent with the historical practice of using the best available data, we are proposing that if more recent LTCH claims data become available, we will use them for determining the fixed-loss amount for FY 2011 in the final rule. Furthermore, we are proposing to determine the proposed FY 2011 fixed-loss amount based on the MS–LTC–DRG classifications and relative weights from the version of the GROUPER that will be in effect as of the beginning of FY 2011, that is, proposed Version 28.0 of the GROUPER (discussed in section VII.B. of the preamble of this proposed rule).

In this proposed rule, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing to establish a fixed-loss amount of $18,692 for FY 2011. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $18,692).

The proposed fixed-loss amount for FY 2011 of $18,692 is slightly higher than the RY 2010 fixed-loss amount of $18,425. Based on our payment simulations using the most recent available data, the proposed slight increase in the fixed-loss amount for FY 2011 would be necessary to maintain the existing requirement that estimated outlier payments would equal 8 percent of estimated total LTCH PPS payments. (For further information on the existing 8 percent HCO "target" requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024.) Maintaining the fixed-loss amount at the current level would result in HCO payments that are greater than the current regulatory requirement 8 percent requirement because a higher fixed-loss amount would result in fewer cases qualifying as outlier cases as well as decreases the amount of the additional payment for a HCO case because the maximum loss that a LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be larger. For these reasons, we believe that proposing to raise the fixed-loss amount is appropriate and necessary to maintain that estimated outlier payments would equal 8 percent

of estimated total LTCH PPS payments as required under § 412.525(a).

4. Application of Outlier Policy to SSO Cases

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the HCO threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as a HCO. Thus, for a SSO case in FY 2011, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $18,692 and the amount paid under the SSO policy as specified in § 412.529).

D. Computing the Proposed Adjusted LTCH PPS Federal Prospective Payments for FY 2011

In accordance with § 412.525, the proposed standard Federal rate is adjusted to account for differences in area wages by multiplying the proposed labor-related share of the proposed standard Federal rate by the appropriate proposed LTCH PPS wage index (as shown in Tables 12A and 12B of the Addendum of this proposed rule). The proposed standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the proposed nonlabor-related share of the proposed standard Federal rate by the appropriate cost-of-living factor (shown in the chart in section V.C.5. of the Addendum of this proposed rule). In this proposed rule, we are proposing to establish a standard Federal rate for FY 2011 of $39,856.75, as discussed in section V.A.2. of the Addendum of this proposed rule. We illustrate the methodology to adjust the proposed LTCH PPS Federal rate for FY 2011 in the following example:

Example: During FY 2011, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). The proposed FY 2011 LTCH PPS wage index value for CBSA 16974 is 1.0573 (Table 12A of the Addendum of this proposed rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a proposed relative weight for FY 2011 of 1.0834 (Table 11 of the Addendum of this proposed rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted proposed Federal prospective payment amount by multiplying the unadjusted proposed standard Federal rate ($39,856.75) by the proposed labor-related share (75.407 percent) and the proposed wage index value (1.0573). This wage-adjusted amount is then added to the proposed nonlabor-related portion of the unadjusted proposed standard Federal rate (24.593 percent; adjusted for cost of living, if applicable) to determine the adjusted proposed Federal rate, which is then multiplied by the proposed MS–LTC–DRG relative weight (1.0834) to calculate the total adjusted proposed Federal LTCH PPS prospective payment for FY 2011 ($45,046.57). The table below illustrates the components of the calculations in this example.

Unadjusted Proposed Standard Federal Prospective Payment Rate	$39,856.75
Proposed Labor-Related Share	x 0.75407
Labor-Related Portion of the Proposed Federal Rate	= $30,054.78
Proposed Wage Index (CBSA 16974)	x 1.0573
Proposed Wage-Adjusted Labor Share of Federal Rate	= $31,776.92
Proposed Nonlabor-Related Portion of the Federal Rate ($39,856.75 x 0.24593)	+ $9,801.97
Adjusted Proposed Federal Rate Amount	= $41,578.89
Proposed MS-LTC-DRG 28 Relative Weight	x 1.0834
Total Adjusted Federal Prospective Payment	= $45,046.57

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 1E, 2, 3A, 3B, 4A, 4B, 4C, 4D–1, 4D–2, 4E, 4F, 4J, 5, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, 11, 12A, and 12B are presented below. Table 6G.—Additions to the CC Exclusions List, Table 6H.—Deletions from the CC Exclusions List, Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions, Table 6J.—Major Complication and Comorbidity (MCC) List, and Table 6K.—Complications and Comorbidity (CC) List are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/.*

We note that, because of the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS, tables 1A, 1B, 1C, 1D, 1E, 2, 4A, 4B, 4C, 4D–1, 4D–2, 4J, 9A, 10, and 11 will need to be updated to reflect these provisions. We plan to issue separate documents in the **Federal Register** and instructions to address these changes and to issue new tables that reflect these provisions.

The tables presented below are as follows:

Table 1A.—Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor (68.8 Percent Labor Share/31.2 Percent Nonlabor Share If Wage Index Is Greater Than 1)

Table 1B.—Proposed National Adjusted Operating Standardized Amounts,

Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C.—Proposed Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Proposed Capital Standard Federal Payment Rate
Table 1E.—Proposed LTCH Standard Federal Prospective Payment Rate
Table 2.—Acute Care Hospitals Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2009; Proposed Hospital Wage Indexes for Federal Fiscal Year 2011; Hospital Average Hourly Wages for Federal Fiscal Years 2009 (2005 Wage Data), 2010 (2006 Wage Data), and 2011 (2007 Wage Data); and 3-Year Average of Hospital Average Hourly Wages
Table 3A.—FY 2011 and 3-Year Average Hourly Wage for Acute Care Hospitals in Urban Areas by CBSA
Table 3B.—FY 2011 and 3-Year Average Hourly Wage for Acute Care Hospitals in Rural Areas by CBSA
Table 4A.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Urban Areas by CBSA and by State—FY 2011
Table 4B.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Rural Areas by CBSA and by State—FY 2011
Table 4C.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals That Are Reclassified by CBSA and by State—FY 2011
Table 4D–1.—Proposed Rural Floor Budget Neutrality Factors for Acute Care Hospitals—FY 2011
Table 4D–2.—Urban Areas with Acute Care Hospitals Receiving the Statewide Rural Floor or Imputed Floor Wage Index—FY 2011
Table 4E.—Urban CBSAs and Constituent Counties for Acute Care Hospitals—FY 2011
Table 4F.—Proposed Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals by CBSA—FY 2011
Table 4J.—Proposed Out-Migration Adjustment for Acute Care Hospitals—FY 2011
Table 5.—List of Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay
Table 6A.—New Diagnosis Codes
Table 6B.—New Procedure Codes
Table 6C.—Invalid Diagnosis Codes
Table 6D.—Invalid Procedure Codes
Table 6E.—Revised Diagnosis Code Titles
Table 6F.—Revised Procedure Code Titles
Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2009 MedPAR Update—December 2009 GROUPER V27.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2009 MedPAR Update—December 2009 GROUPER V28.0 MS–DRGs
Table 8A.—Proposed Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8B.—Proposed Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8C.—Proposed Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs—March 2009
Table 9A.—Hospital Reclassifications and Redesignations—FY 2011
Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2011
Table 10.—Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Medicare Severity Diagnosis-Related Group (MS–DRG) —March 2009
Table 11.—Proposed MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for Discharges Occurring from October 1, 2010 through September 30, 2011 under the LTCH PPS
Table 12A.—Proposed LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2010 through September 30, 2011
Table 12B.—Proposed LTCH PPS Wage Index for Rural Areas for Discharges Occurring From October 1, 2010 through September 20, 2011

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TABLE 1A.—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (68.8 PERCENT LABOR SHARE/31.2 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)

Full Update (2.4 Percent)		Reduced Update (0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,566.91	$1,617.55	$3,497.24	$1,585.96

TABLE 1B.—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)

Full Update (2.4 Percent)		Reduced Update (0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,214.37	$1,970.09	$3,151.58	$1,931.62

TABLE 1C.—PROPODSED ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,566.91	$1,617.55	$3,214.37	1,970.09
Puerto Rico	$1,530.25	$933.92	$1,527.79	$936.38

TABLE 1D.—PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$420.99
Puerto Rico	$199.43

TABLE 1E.—PROPOSED LTCH STANDARD FEDERAL PROSPECTIVE PAYMENT RATE

	Rate
Standard Federal Rate	$39,856.75

TABLE 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2009; PROPOSED HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2011; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2009 (2005 WAGE DATA), 2010 (2006 WAGE DATA), AND 2011 (2007 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage[**] (3 years)
010001	1.6908	0.8539	25.0592	24.8712	27.6011	25.8542
010005	1.2841	0.8427	25.7771	24.9052	26.7660	25.7876
010006	1.4782	0.8028	25.1401	26.7013	27.1899	26.3024
010007	1.0377	0.7448	22.0185	20.0565	21.0524	21.0330
010008	1.1123	0.7622	23.2572	22.8443	24.6733	23.5882
010009	0.9990	0.8646	25.8420	26.1396	27.7497	26.5428
010010	1.2246	0.7744	24.8390	26.2416	27.1969	26.0938
010011	1.5830	0.8614	27.1997	28.6140	33.0361	29.6023
010012	1.1634	0.7634	26.4989	24.8944	25.4141	25.5688
010015	0.9011	0.7494	23.6821	22.9857	22.2077	22.9349
010016	1.5802	0.8614	28.9724	28.7392	30.3170	29.3596
010018	1.1555	0.8614	26.9514	26.7633	28.8087	27.5186
010019	1.3603	0.8028	25.0170	26.0567	29.0622	26.7038
010021	1.3329	0.7571	21.7601	24.3385	25.0343	23.6912
010022	0.9217	0.9563	28.7529	26.5348	30.6579	28.6538
010023	1.7864	0.8506	28.2135	30.0684	31.4256	29.9233
010024	1.6738	0.8506	26.6636	28.1766	29.2979	28.1013
010025	1.4344	0.8613	23.8617	20.1873	29.5803	23.9653
010027	0.7496	0.7510	18.2508	19.7740	22.3038	20.2061
010029	1.6510	0.8613	24.3622	28.3184	26.2864	26.2272
010032	0.8693	0.7773	20.8458	24.7706	22.5607	22.8612
010033	2.2117	0.8614	29.2036	29.3762	30.8243	29.8385
010034	1.1730	0.8506	21.3728	21.0565	23.7513	22.0213
010035	1.3475	0.8427	26.5299	28.0534	28.4993	27.6832
010036	1.1875	0.7448	23.3876	25.0011	25.7199	24.7026
010038	1.3776	0.7945	28.9646	29.7948	32.5231	30.4750
010039	1.8330	0.8994	29.8034	30.6619	31.7063	30.7533
010040	1.6522	0.7561	25.9856	25.2840	27.2842	26.1688
010043	1.2776	0.8614	25.3633	27.3636	26.3517	26.3192
010044	1.0295	0.7448	23.4020	27.3403	28.2131	26.2653
010045	1.0535	0.7670	24.2450	25.1108	27.0851	25.4649

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
010046	1.5582	0.8427	25.4465	33.3112	21.9429	26.0994
010047	0.8765	0.7575	21.7349	17.0984	24.5251	21.0332
010049	1.0744	0.7510	23.1194	25.4446	27.0625	25.1500
010050	1.0266	0.8614	25.3678	27.0365	29.5491	27.2877
010051	0.8615	0.8225	20.0765	21.4140	20.9159	20.8071
010052	0.9419	0.8506	22.7571	22.1386	21.8148	22.2484
010054	1.0674	0.8646	25.4209	24.6126	24.5639	24.8520
010055	1.5928	0.8002	25.3306	26.4706	26.7456	26.1757
010056	1.6143	0.8614	25.7290	28.5668	31.1851	28.4494
010058	0.9816	0.8614	31.1865	23.6860	24.6105	25.8253
010059	1.0664	0.8646	27.8613	29.5434	26.7428	27.9872
010061	0.9602	0.8594	25.7048	26.5035	26.1463	26.1214
010062	1.0748	0.7743	22.9491	20.8224	23.0559	22.2543
010064	1.6120	0.8614	26.6333	*	23.3954	24.8292
010065	1.4982	0.8427	24.4454	25.9433	27.7120	26.0207
010066	0.8151	0.7448	25.6052	25.9301	26.7367	26.0555
010069	0.9679	0.7448	27.3438	29.4662	25.8964	27.5684
010073	0.9744	0.7448	20.7833	19.9743	21.0063	20.5785
010078	1.7376	0.7945	25.2897	24.5429	26.5654	25.4734
010079	1.3594	0.8994	23.1025	25.4118	27.2463	25.2397
010083	1.1948	0.7899	25.0422	25.2405	25.2017	25.1655
010084	***	*	27.5069	*	*	27.5069
010085	1.4769	0.8646	24.0475	25.6072	26.5909	25.3882
010086	1.1077	0.7448	26.9753	24.9468	27.4146	26.3789
010087	2.4471	0.7899	27.4929	27.2725	26.8954	27.1988
010089	1.3862	0.8614	25.9719	26.9357	27.9079	26.8958
010090	1.8308	0.7899	25.6110	26.8029	28.3744	26.9471
010091	0.8685	0.7494	23.6555	27.8571	25.1201	25.3701
010092	1.5529	0.8225	28.8433	30.3263	28.7948	29.3311
010095	0.7991	0.8225	17.8248	21.6551	23.5564	21.0352
010097	0.8060	0.8506	18.4218	19.5147	21.2996	19.7766
010099	0.9382	0.7448	22.3686	20.8632	23.5835	22.2682
010100	1.7378	0.8144	25.4357	25.8178	26.8181	26.0446
010101	1.1605	0.8427	26.2744	25.0955	26.5747	25.9872
010102	0.9608	0.8506	26.6943	22.6883	22.4398	23.9594
010103	1.9636	0.8614	30.4032	27.9049	29.7010	29.3261
010104	1.6984	0.8614	30.4963	29.1001	30.1353	29.9264

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
010108	1.0545	0.8506	26.8900	27.7601	29.5101	28.1758
010109	1.0134	0.7757	21.9300	19.3990	23.0918	21.4719
010110	0.8328	0.7663	22.1175	17.9438	25.5691	21.8242
010112	0.9041	0.7448	21.3904	22.0927	20.9602	21.4581
010113	1.6548	0.7899	25.0704	25.7852	28.0528	26.3173
010114	1.5070	0.8614	25.3666	25.8015	25.6005	25.5885
010118	1.3294	0.8015	25.3689	25.7663	27.7362	26.2760
010120	0.9119	0.7448	22.8177	22.0809	*	22.4473
010125	1.1026	0.7924	23.6549	24.1942	25.4328	24.3975
010126	1.0242	0.8506	25.7254	28.8995	27.0770	27.1824
010128	0.9834	0.7494	25.9421	25.1022	25.7453	25.6021
010129	1.1598	0.7582	24.4816	25.2104	27.6767	25.7944
010130	1.0145	0.8614	25.2790	23.8895	31.2319	26.5261
010131	1.4270	0.8994	28.0487	28.6759	32.2481	29.7152
010137	1.5361	0.8614	30.4361	30.7312	33.4983	31.5313
010138	0.6398	0.7514	15.0815	16.7541	16.6144	16.1902
010139	1.6830	0.8614	29.3560	29.3626	30.7489	29.8142
010143	1.1691	0.8646	25.0871	25.1522	25.9745	25.3833
010144	1.7207	0.7899	23.8601	25.4614	26.4008	25.1949
010145	1.5795	0.8225	27.3296	30.2093	29.5558	29.0313
010146	0.9412	0.7945	23.8076	24.6572	25.2484	24.5514
010148	0.9563	0.7448	25.0960	24.8409	24.3699	24.7693
010149	1.3663	0.8506	26.8920	28.1328	29.5254	28.2683
010150	1.0187	0.7575	25.0070	26.3342	25.9401	25.7372
010152	1.3718	0.7899	26.0793	23.0248	26.8322	25.2347
010157	1.1568	0.8028	27.1793	27.5674	27.3487	27.3636
010158	1.3394	0.7583	26.2363	26.8821	27.7665	26.9653
010164	1.1777	0.8427	25.6759	24.4625	23.9304	24.6859
010167	1.5767	0.8614	*	24.7643	29.1631	26.8653
010168	1.6115	0.9111	*	30.2040	27.0185	28.8600
010169	1.0410	*	*	*	*	*
020001	1.8974	1.1919	38.1784	39.2651	40.8325	39.4363
020006	1.3723	1.1919	37.2853	40.5422	42.4838	40.2757
020008	1.2207	1.1919	40.6783	42.8075	44.8291	42.8366
020012	1.4672	1.1919	36.1911	37.0181	38.4880	37.2462
020014	***	*	30.6343	*	*	30.6343
020017	2.2168	1.1919	38.2157	41.2448	42.1762	40.5573

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
020018	0.9117	1.8246	*	*	*	*
020024	1.1323	1.1919	39.9943	35.9358	43.5298	39.9069
020026	1.5829	1.8246	*	*	*	*
020027	0.8544	1.8246	*	*	*	*
020028	***	*	*	*	42.1568	42.1568
030001	1.5123	1.0519	35.9083	38.1204	36.9465	37.0095
030002	2.1395	1.0519	32.9094	34.2998	35.5406	34.2817
030006	1.7866	0.9692	29.1248	32.1646	32.4565	31.2997
030007	1.5010	1.2318	35.5226	38.1199	40.1726	38.0212
030010	1.6899	0.9692	31.8640	33.3049	33.9522	33.0660
030011	1.6799	0.9692	30.2096	31.8532	32.9183	31.7320
030012	1.6785	1.2318	31.3068	33.4818	50.8525	36.5891
030013	1.5846	0.9455	31.9162	31.1767	33.0103	32.0532
030014	1.6003	1.0519	30.6308	31.8529	33.7100	32.1295
030016	1.3364	1.0519	31.1878	30.6196	34.0540	31.8987
030017	***	*	34.8488	34.9499	37.4893	35.7433
030018	***	*	31.7240	34.2870	35.7209	33.8731
030019	***	*	33.6553	36.3298	36.3760	35.4444
030022	1.6387	1.0519	35.0772	34.3377	34.4050	34.5355
030023	2.0211	1.2457	37.5523	41.8098	43.4901	40.9837
030024	2.1783	1.0519	35.3556	38.5575	40.6081	38.3107
030030	1.6996	1.0519	36.4772	38.9056	37.5980	37.7197
030033	1.3578	1.0519	32.0362	33.9716	35.7840	33.9594
030036	1.6971	1.0519	35.7464	37.1271	40.4842	37.7767
030037	1.9779	1.0519	35.1342	35.8129	37.1935	36.2152
030038	1.6840	1.0519	31.2928	33.8052	36.9266	34.1148
030043	1.3149	0.9120	28.3158	29.0816	31.0593	29.4840
030055	1.5838	1.0287	31.0806	37.2632	37.4315	35.3174
030061	1.7125	1.0519	33.0847	34.2000	35.3864	34.2660
030062	1.4495	0.9120	29.9359	30.3859	33.1874	31.2110
030064	2.1061	0.9692	31.6632	33.1535	35.0230	33.3240
030065	1.8343	1.0519	31.4602	33.8941	36.2534	33.8318
030067	1.0416	0.9418	27.0784	27.4410	31.2478	28.5865
030068	1.1142	0.9120	26.0296	26.8369	28.7966	27.2639
030069	1.5878	1.1429	30.7723	35.1793	35.6421	33.9927
030071	1.0518	1.4448	*	*	*	*
030073	1.2775	1.4448	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
030074	0.9561	1.4448	*	*	*	*
030077	0.9180	1.4448	*	*	*	*
030078	1.2123	1.4448	*	*	*	*
030080	***	*	30.7682	34.2723	*	32.4902
030083	1.5477	1.0519	35.8521	39.0888	39.9707	38.3254
030084	1.0830	1.4448	*	*	*	*
030085	1.6913	0.9692	29.0774	30.7160	33.4062	31.0315
030087	1.7697	1.0519	31.1094	33.0362	37.2751	33.9611
030088	1.4335	1.0519	30.5738	33.5408	34.6877	33.0355
030089	1.7404	1.0519	31.3179	32.8874	34.7343	33.0017
030092	1.6022	1.0519	30.4394	31.6471	33.8309	32.0855
030093	1.4573	1.0519	33.0720	33.5029	34.3015	33.6746
030094	1.6808	1.0519	34.2040	35.9213	36.9133	35.7448
030099	0.7231	*	24.9127	*	*	24.9127
030100	2.2953	0.9692	35.0981	36.9783	39.5385	37.2928
030101	1.4411	1.1811	33.2139	34.1060	33.6260	33.6535
030102	2.8130	1.0519	36.9539	39.4617	36.4149	37.5421
030103	1.8002	1.0519	34.2770	41.6469	41.1210	39.1558
030105	2.2878	1.0519	33.9875	37.6952	38.6741	36.8267
030106	***	*	40.1657	43.9022	*	41.9807
030107	2.1093	1.0519	35.4562	35.9171	37.6288	36.3377
030108	2.4034	1.0519	34.8507	33.2799	34.5124	34.1536
030110	1.7329	1.0519	36.2158	38.0468	39.0340	37.8801
030111	1.1668	0.9692	28.5146	33.3314	37.0123	33.6486
030112	2.0671	1.0519	33.4810	36.1513	40.1301	36.8711
030113	0.9505	1.4448	*	*	*	*
030114	1.4510	0.9692	28.8466	30.2128	30.3754	29.8451
030115	1.5083	1.0519	32.5885	34.8409	36.8225	35.0086
030117	1.3318	1.0287	*	34.5349	36.6725	35.7305
030118	1.3327	1.2318	*	28.2945	32.6116	30.4114
030119	1.6200	1.0519	*	38.2362	40.7172	39.6384
030120	0.8520	1.0519	*	39.7676	47.5037	43.8726
030121	1.6902	1.0519	*	*	36.6999	36.6999
030122	1.4640	1.0519	*	*	35.1781	35.1781
030123	1.4739	1.0519	*	*	*	*
030124	1.8948	1.0519	*	*	*	*
030125	2.0742	1.0519	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
030126	1.8635	1.0519	*	*	*	*
040001	1.0932	0.8648	24.4962	25.0147	25.5841	25.0463
040002	1.1071	0.7517	24.0487	26.2100	24.0639	24.7422
040004	1.7351	0.8648	29.2714	30.1320	31.6130	30.3580
040007	1.7451	0.8675	28.3305	29.3146	30.2051	29.2717
040010	1.4698	0.8648	28.2375	28.1618	29.2017	28.5990
040011	0.9266	0.7517	22.6327	25.6224	25.9642	24.7357
040014	1.3689	0.8490	34.8279	24.1271	24.6941	25.6001
040015	1.0662	0.7517	22.3148	23.2134	23.7403	23.0850
040016	1.7601	0.8675	26.4806	27.6568	28.6501	27.6411
040017	1.0990	0.8127	24.3772	25.3390	26.2509	25.3116
040018	1.2191	0.7742	26.2521	25.3362	26.6851	26.0819
040019	0.9918	0.7775	26.4932	25.5468	25.0491	25.6618
040020	1.6272	0.7833	26.1529	25.9754	26.6049	26.2463
040021	***	*	27.6799	28.7690	28.8903	28.4564
040022	1.4167	0.8648	30.0250	29.5992	29.4604	29.6905
040026	1.6410	0.9296	31.8588	32.2814	34.6944	32.9479
040027	1.5093	0.8413	25.7935	27.2441	28.4743	27.1878
040029	1.4958	0.8675	27.8882	27.8412	29.1988	28.3053
040036	1.6856	0.8675	30.4906	32.0772	33.1236	31.9038
040039	1.1753	0.8127	22.9807	23.4456	23.0760	23.1655
040041	1.1592	0.8490	26.4435	27.8594	27.4448	27.2474
040042	1.3566	0.9213	23.1661	23.5768	28.3874	25.0294
040047	0.9113	0.7634	23.3557	25.0102	27.5142	25.1265
040050	1.1590	0.7517	19.6946	21.0178	22.0146	20.9063
040051	0.9936	0.7517	22.1981	23.4783	24.9308	23.5416
040055	1.7558	0.7742	26.0150	26.3370	26.5702	26.3163
040062	1.6827	0.7742	25.6554	28.5888	28.4309	27.5460
040067	1.0555	0.7524	20.9700	21.3492	22.1772	21.5146
040069	0.9730	0.8127	23.3117	23.0880	22.6987	23.0306
040071	1.5474	0.8490	26.6645	25.0185	28.7130	26.7537
040072	1.1859	0.7517	22.9671	23.3205	24.0488	23.4429
040074	1.1781	0.8675	27.3897	27.4614	27.7915	27.5518
040076	1.0157	0.9071	24.7903	25.7464	25.0274	25.1722
040078	1.7507	0.9296	25.6886	27.9394	28.4481	27.3094
040080	1.0416	0.7833	26.5905	26.9354	26.1224	26.5524
040081	0.8641	0.7874	18.4759	18.5265	17.3969	18.1445

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
040084	1.3107	0.8675	28.1570	28.7379	29.9634	29.0185
040085	0.9358	0.8981	26.6987	25.4981	26.7545	26.3201
040088	1.5419	0.8122	24.7119	26.7050	28.8877	26.7762
040091	1.1940	0.7517	22.3311	27.7747	29.9029	26.3939
040100	***	*	24.5458	24.7712	*	24.6638
040114	1.9109	0.8675	28.5702	29.1200	30.6358	29.4351
040118	1.6136	0.7517	26.5783	27.3360	30.6065	28.2493
040119	1.5157	0.8490	25.6779	26.9632	28.2765	27.0150
040132	0.8021	0.9296	21.8140	*	22.6953	22.2510
040134	2.2362	0.8675	34.9673	35.2045	36.1627	35.4829
040137	1.3325	0.8675	27.7638	28.2123	31.3247	29.2690
040138	***	*	33.0073	31.1138	32.6001	32.2159
040141	***	*	33.8791	34.8500	*	34.4114
040142	1.5826	0.9296	23.1302	24.4876	27.5086	25.1151
040145	1.9580	0.7833	20.3878	22.1731	22.3687	21.7125
040147	1.9130	0.8675	35.7669	33.6215	30.4256	32.7938
040148	***	*	*	*	35.6031	35.6031
040149	***	*	*	*	29.0721	29.0721
040152	2.5966	0.8648	*	*	*	*
050002	1.5159	1.5855	43.1760	42.3825	45.4953	43.6748
050006	1.8102	1.3277	41.7714	43.8923	45.0094	43.5856
050007	1.5598	1.5182	49.5271	55.1636	52.2245	52.2511
050008	1.6354	1.5036	50.9569	50.4751	52.7669	51.4050
050009	1.7626	1.5173	49.7177	51.5510	53.0588	51.5292
050013	1.9184	1.5173	43.4906	46.3422	49.5453	46.5172
050014	1.2657	1.3217	42.2044	42.7255	41.0206	41.9545
050016	1.4193	1.2121	34.3863	36.3674	39.4584	36.8709
050017	2.1061	1.3217	44.4857	46.6209	48.7220	46.6321
050018	1.3007	1.2002	34.0338	34.7941	36.0324	34.9615
050022	1.7904	1.2002	36.6360	38.9203	41.5471	39.0977
050024	1.2891	1.2002	33.5247	34.6921	37.1807	34.9055
050025	1.9538	1.2002	36.9233	39.5330	42.5246	39.7669
050026	1.6191	1.2002	35.0306	36.3315	37.3290	36.2935
050028	1.2261	1.2002	28.1584	28.5839	*	28.3806
050030	1.2680	1.2002	33.5654	33.2455	34.4700	33.7632
050036	1.7457	1.2002	37.4298	39.2616	41.5393	39.4707
050038	1.7728	1.6059	55.2197	58.4851	61.3276	58.4346

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050039	1.5400	1.2002	34.9262	37.8559	40.9213	37.8428
050040	1.3721	1.2002	38.1665	41.9767	44.2571	41.5266
050042	1.5785	1.3277	40.5791	45.6660	50.9908	45.8022
050043	1.7576	1.5855	51.9529	55.4677	53.5411	53.6961
050045	1.3696	1.2002	28.5952	27.8903	31.4860	29.3287
050046	1.2182	1.2002	34.2529	34.0106	37.1982	35.1676
050047	1.8545	1.5036	48.5961	51.4298	53.1141	51.0350
050054	1.2411	1.2002	27.1320	27.9082	32.4947	29.1694
050055	1.4904	1.5036	48.2796	51.9993	52.9342	51.0882
050056	1.5972	1.2002	34.7964	33.2655	39.4954	35.7797
050057	1.6940	1.2002	33.7574	35.6340	38.6138	36.0669
050058	1.8187	1.2002	38.9843	41.4811	43.4764	41.3510
050060	1.6287	1.2002	34.1183	35.3108	36.7750	35.4314
050063	1.6524	1.2002	36.6301	40.9558	43.3599	40.2753
050065	***	*	42.0085	*	*	42.0085
050067	1.3773	1.2002	41.8988	41.1549	34.0218	39.0746
050069	2.0169	1.2002	38.1339	40.0498	44.2637	40.8835
050070	1.4481	1.5182	48.9362	53.8300	55.6284	52.8293
050071	1.7718	1.6059	52.0696	55.3995	54.9153	54.1707
050072	1.5282	1.5536	51.4538	54.7774	55.8299	54.0528
050073	1.5376	1.5428	50.6523	54.2296	55.8359	53.6371
050075	1.6153	1.5855	51.1187	54.8332	56.6372	54.2184
050076	1.8135	1.5036	50.5761	53.8043	55.1835	53.2013
050077	1.6624	1.2002	37.4989	38.5242	38.0509	38.0339
050078	1.3299	1.2002	37.1940	38.9256	38.8489	38.3347
050079	1.5469	1.5536	48.3017	50.6578	65.1440	53.7676
050082	1.8234	1.2002	42.0181	41.8861	44.1069	42.6942
050084	1.6992	1.3217	41.1276	42.4418	46.0253	43.2693
050089	1.4757	1.2002	39.6297	39.9711	42.3990	40.7121
050090	1.4461	1.5428	41.6026	44.0838	44.4628	43.3851
050091	0.9802	1.2002	40.1063	34.8170	33.6732	36.0063
050093	1.5991	1.2002	37.7244	38.5686	41.6205	39.3792
050095	***	*	44.2400	*	*	44.2400
050096	1.4571	1.2002	33.3803	27.6236	33.2850	31.4278
050099	1.6444	1.2002	34.3507	35.4717	37.9297	35.9486
050100	1.8716	1.2002	34.2839	37.1606	39.4312	36.9821
050101	1.6391	1.5428	48.7495	54.5185	56.2550	53.2934

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050102	1.4707	1.2002	33.2837	35.4740	35.1267	34.5871
050103	1.6949	1.2002	37.3608	38.8446	38.1720	38.1428
050104	1.5783	1.2002	37.4417	39.1121	41.8962	39.5439
050107	1.6748	1.2002	36.5843	40.5315	41.9627	39.7421
050108	2.0166	1.3217	45.3460	48.8199	53.1654	48.7805
050110	1.2043	1.2002	30.9054	32.3171	33.5933	32.2754
050111	1.0887	1.2002	31.9394	31.1160	32.2597	31.7697
050112	1.5483	1.2002	39.9951	41.8195	41.5924	41.1912
050113	1.4076	1.5182	46.3471	45.1998	42.4778	44.6111
050114	***	*	37.5924	36.6541	*	37.1115
050115	1.5983	1.2002	33.3013	37.7614	40.4397	37.1497
050116	1.7304	1.2002	45.7510	40.6863	42.7961	43.0779
050118	1.2522	1.2002	41.8191	43.4432	46.9088	44.0974
050121	1.2757	1.2002	35.1135	36.9069	41.8043	38.1805
050122	1.7509	1.2384	36.8821	40.4510	41.5112	39.6349
050124	1.3527	1.2002	31.7690	33.3080	34.6304	33.2610
050125	1.6861	1.6059	53.6300	57.6242	60.2474	57.1280
050126	1.6064	1.2002	35.1909	34.9807	36.0294	35.4292
050127	1.5461	1.3217	42.5226	46.9648	48.0928	46.1911
050128	1.6196	1.2002	34.2364	36.6986	39.3773	36.7615
050129	1.9659	1.2002	40.3786	41.4256	44.5762	42.1957
050131	1.4681	1.5428	52.8228	56.6586	53.6221	54.3340
050132	1.6276	1.2002	43.6747	42.8187	45.1737	43.9116
050133	1.4848	1.2180	35.2433	36.8254	37.6504	36.6555
050135	1.0726	1.2002	25.4431	28.5118	30.6553	28.0980
050136	1.4481	1.5428	51.8508	52.5398	57.3918	53.8780
050137	1.3773	1.2002	43.5305	45.2088	49.1420	45.8667
050138	1.9128	1.2002	45.1011	47.3839	51.2980	47.9183
050139	1.4368	1.2002	43.0734	44.5753	48.6963	45.4255
050140	1.4087	1.2002	42.7590	44.8911	46.8652	44.8787
050144	***	*	40.4760	*	*	40.4760
050145	1.6332	1.5512	49.4479	54.8909	58.5220	54.4145
050146	1.8322	*	*	*	*	*
050149	1.5052	1.2002	43.1926	42.8003	45.3498	43.7950
050150	1.3011	1.3217	43.5937	44.3354	48.0733	45.3350
050152	1.6955	1.5428	54.7176	55.9738	57.1905	55.9904
050153	1.5690	1.6059	50.4884	53.5925	57.8841	54.0652

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050158	1.5055	1.2002	42.7874	42.9454	44.0747	43.2830
050159	1.3444	1.2002	35.0153	40.4701	42.5924	39.5664
050167	1.4923	1.2384	38.0742	39.9946	41.8816	40.0050
050168	1.6873	1.2002	40.8362	37.9746	43.4951	40.7650
050169	1.6805	1.2002	33.1130	35.4836	41.1246	36.5888
050173	1.3930	1.2002	32.3265	31.5434	32.8423	32.2554
050174	1.7399	1.5428	53.7113	54.7960	59.7549	56.0844
050179	1.2738	1.2002	34.6558	36.2060	33.9197	34.8615
050180	1.7149	1.5536	48.7425	51.1836	53.5567	51.2533
050188	1.4966	1.6059	45.8501	49.6669	54.1865	49.5983
050189	0.9575	1.5512	31.5805	27.5311	29.3459	29.4661
050191	1.6765	1.2002	41.7185	40.0694	41.5164	41.0746
050192	0.9069	1.2002	27.4611	29.4203	33.2102	30.1271
050193	1.2942	1.2002	36.7240	39.0111	43.0282	39.5133
050194	1.3701	1.6059	49.8539	49.9857	55.1169	51.6953
050195	1.6650	1.5855	57.6563	61.8312	65.0039	61.5445
050196	1.2008	1.2002	41.1300	43.7415	41.0270	41.9842
050197	1.9331	1.5855	55.3173	59.0280	63.2066	59.2051
050204	1.5451	1.2002	38.8689	37.5591	41.0566	39.2215
050205	1.5945	1.2002	30.6117	30.2818	31.5240	30.7776
050211	1.3252	1.5855	42.9254	44.8773	46.1770	44.5820
050219	1.3542	1.2002	26.7061	26.9022	26.0523	26.5448
050222	1.7729	1.2002	35.4045	36.0221	37.6975	36.4283
050224	1.7191	1.2002	37.3442	39.7119	41.8790	39.6769
050225	1.5650	1.2002	37.5252	38.9288	42.8450	39.8661
050226	1.5718	1.2002	36.5354	38.4952	39.4194	38.1228
050228	1.4239	1.5036	49.9063	54.5580	57.3422	54.0697
050230	1.7061	1.2002	38.8901	39.8582	42.1567	40.3322
050231	1.8460	1.2002	37.0245	38.7280	40.2191	38.7139
050232	1.7131	1.2121	35.4055	39.4290	42.5544	39.2518
050234	1.5381	1.2002	37.7125	37.6811	38.9602	38.1603
050235	1.7383	1.2002	39.1744	40.0962	40.2265	39.8347
050236	1.5208	1.2002	34.4257	42.5939	44.3842	40.4072
050238	1.7269	1.2002	35.1268	36.4272	37.0926	36.2576
050239	1.6695	1.2002	36.3257	37.2939	38.5937	37.4489
050242	1.4892	1.6059	53.8385	58.5684	59.7332	57.3859
050243	1.6103	1.2002	37.8538	40.0490	42.5305	40.1509

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050245	1.3766	1.2002	34.7153	36.9270	37.1180	36.2906
050248	1.1998	1.5512	46.0329	47.7637	51.0500	48.2742
050254	1.3843	1.3217	33.5069	34.8262	39.7976	36.0829
050256	***	*	32.6841	*	*	32.6841
050257	0.8947	1.2002	29.2651	30.7766	29.8486	29.9463
050261	1.3026	1.2002	33.7196	34.8188	39.3041	36.0518
050262	2.3736	1.2002	43.7709	40.8071	44.0453	42.8188
050264	1.4655	1.5855	50.1691	54.4052	57.0188	53.7398
050272	1.5454	1.2002	32.2584	35.0624	37.3015	34.8914
050276	1.1140	1.5536	47.2432	53.7552	55.4715	52.2517
050277	1.2258	1.2002	*	48.9698	47.5707	48.2343
050278	1.7099	1.2002	38.5689	39.5929	42.8799	40.4121
050279	1.3099	1.2002	32.1695	31.0888	31.6803	31.6436
050280	1.8248	1.3277	43.6243	46.2628	50.0266	46.6861
050281	1.5342	1.2002	31.0706	31.4166	32.8623	31.7857
050283	1.7021	1.5855	45.1132	50.3066	51.3746	48.9680
050289	1.6807	1.5182	52.0918	53.8571	58.3774	54.8745
050290	1.7520	1.2002	42.0099	42.2249	42.6314	42.2987
050291	2.0918	1.5428	44.6102	49.6427	52.1353	48.7155
050292	1.1648	1.2002	35.0372	34.6404	39.9841	36.7557
050295	1.5834	1.2002	39.7399	39.3961	42.9356	40.7188
050296	1.1416	1.6044	44.8135	48.2583	50.4082	47.9062
050298	1.2079	1.2002	33.6947	31.7374	34.0150	33.1345
050300	1.4557	1.2002	37.1275	39.2722	43.0474	40.0013
050301	1.3483	1.2002	36.3681	36.7568	39.9485	37.7770
050305	1.5667	1.5855	56.9756	55.7229	54.6309	55.7281
050308	1.5864	1.6059	49.0132	51.0183	54.0475	51.4737
050309	1.5729	1.3217	42.9280	46.6901	47.4734	45.7112
050313	1.2453	1.2384	39.0663	42.3998	43.8913	41.8600
050315	1.4388	1.2002	37.3560	40.3132	47.1318	41.7255
050320	1.2324	1.5855	50.6708	50.9692	55.3663	52.3385
050324	1.8098	1.2002	37.1883	38.9511	41.1149	39.1426
050325	0.7767	1.2035	34.0343	*	47.6656	36.0502
050327	1.8597	1.2002	36.9550	37.7681	39.6815	38.2025
050329	1.3249	1.2002	36.7669	37.6975	37.0324	37.1628
050334	1.7820	1.5855	50.9834	54.9338	59.6727	55.2808
050335	1.4895	1.2002	37.2347	37.1670	39.1873	37.9135

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050336	1.2295	1.2384	33.0325	35.3658	38.7257	35.7910
050342	1.2591	1.2002	29.8389	31.6852	33.8443	31.8494
050348	1.7579	1.2002	33.5276	35.1080	37.4660	35.3772
050349	0.7643	1.2002	23.1095	23.5190	24.5969	23.7436
050350	1.5328	1.2002	34.6747	36.1856	37.1989	35.9750
050351	1.5646	1.2002	35.0042	35.6083	34.8470	35.1393
050352	1.4182	1.3217	38.6265	41.5370	41.4294	40.5216
050353	1.5266	1.2002	37.1716	37.4560	38.3124	37.6445
050357	1.4556	1.2002	38.9244	40.9999	41.8008	40.6080
050359	1.1943	1.2002	30.3988	30.9732	33.5096	31.6303
050360	1.6360	1.5428	55.3738	59.2147	57.2879	57.3315
050366	1.1199	1.3217	41.8324	43.0169	43.1165	42.6581
050367	1.6146	1.5428	40.0453	41.1059	44.3506	41.9320
050369	***	*	33.3357	34.7337	37.3679	35.1733
050373	1.4497	1.2002	37.6695	40.8506	43.5055	40.7260
050376	1.6492	1.2002	36.7270	40.0354	42.4754	39.8599
050378	1.1137	1.2002	42.0480	50.0875	51.5092	47.5470
050380	1.8224	1.6059	52.5804	58.6395	60.9625	57.5372
050382	1.6019	1.2002	32.9248	34.3636	36.6641	34.7208
050385	1.4871	1.5428	36.5644	38.9773	44.3026	40.0228
050390	1.2847	1.2002	33.0463	31.4134	33.7927	32.7377
050393	1.4304	1.2002	35.1887	35.5678	38.9873	36.6236
050394	1.7929	1.2002	32.9572	37.2557	40.0176	36.7479
050396	1.5923	1.2002	38.9944	41.2602	41.6933	40.7032
050397	0.8415	1.2002	31.1621	32.3700	36.0861	33.4783
050407	1.2178	1.5036	47.5591	47.7943	48.9123	48.1149
050411	1.4376	1.2002	42.9884	44.3404	47.5402	44.9714
050414	1.3420	1.3217	45.1621	48.5863	51.1532	48.4113
050417	1.3322	1.2002	37.9951	38.8418	38.4087	38.4269
050423	1.0535	1.2002	32.4108	41.3130	43.7795	38.6501
050424	1.9481	1.2002	37.5246	39.8802	42.7414	40.2044
050425	1.4308	1.3217	45.3743	52.0378	53.7887	50.3034
050426	1.7182	1.2002	37.6505	*	37.1444	37.3893
050430	1.0514	*	25.9368	28.7102	*	27.6338
050433	***	*	23.0949	*	*	23.0949
050434	0.9730	1.2002	35.4807	34.4698	36.3651	35.4609
050435	1.2470	1.2002	35.7427	35.3040	36.3716	35.8152

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050438	1.6093	1.2002	38.2855	36.8507	37.7652	37.6241
050441	2.0773	1.6059	49.2129	50.0652	56.1662	51.9914
050444	1.4821	1.2235	39.3947	39.4231	41.6899	40.2059
050447	***	*	27.1271	*	*	27.1271
050448	1.2055	1.2002	32.6682	32.9244	35.5744	33.7517
050454	2.1384	1.5036	43.5230	46.9602	50.6105	47.1838
050455	1.5674	1.2002	35.0232	38.9871	39.4869	37.8773
050456	***	*	27.9702	28.1444	*	28.0651
050457	1.7524	1.5036	53.3175	54.6802	57.1259	55.0565
050464	1.8533	1.2002	42.6699	44.9128	46.6301	44.6843
050468	1.5593	1.2002	37.3416	35.7136	37.0600	36.6946
050470	***	*	32.5041	*	*	32.5041
050471	1.6569	1.2002	36.8185	37.6641	40.5399	38.3240
050476	***	*	41.7566	*	*	41.7566
050478	0.9581	1.2002	41.5635	44.3775	46.6521	44.3460
050481	1.6201	1.2002	42.8536	47.2326	50.1977	46.8143
050485	1.7165	1.2002	34.7078	37.4203	39.3266	37.2228
050488	1.5157	1.5855	49.3604	53.8013	53.3366	52.2027
050492	1.4172	1.2002	32.6609	35.6838	39.4538	36.0641
050496	1.8243	1.5536	56.7446	57.1030	61.4808	58.5059
050498	1.4628	1.3217	45.3508	46.6560	47.6863	46.5454
050502	1.7474	1.2002	32.9791	40.2876	37.2580	36.7036
050503	1.5401	1.2002	37.7210	40.7324	43.1770	40.6385
050506	1.5155	1.2121	40.6534	42.3670	45.0204	42.6481
050510	1.4186	1.5428	51.3143	54.8690	55.9873	54.0800
050512	1.4447	1.5855	50.1470	53.9292	55.7732	53.3348
050515	1.4010	1.2002	42.0106	45.0972	48.0118	45.0227
050516	1.6158	1.3217	45.6228	48.5267	48.0618	47.4427
050517	1.4708	1.2002	29.3694	29.8385	27.5129	28.8628
050523	1.3871	1.5536	46.9870	49.5029	53.7305	50.2368
050526	1.4939	1.2002	35.5457	*	36.5894	36.0188
050528	1.1577	1.2002	38.3051	41.9922	43.2318	41.2013
050531	1.1682	1.2002	28.4890	28.4921	31.0366	29.3122
050534	1.6008	1.2002	38.1892	39.7655	42.3047	40.1251
050537	1.6440	1.3217	41.5275	43.1765	45.7187	43.4999
050541	1.6420	1.5855	51.4545	55.2594	56.3321	54.3652
050543	0.7871	1.2002	32.8367	29.0470	31.0801	30.9554

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050545	0.9027	1.2002	*	27.4889	*	27.4889
050547	1.0068	1.5428	*	*	*	*
050548	0.7480	1.2002	*	*	*	*
050549	1.6820	1.2002	40.6796	44.6715	46.9107	44.1208
050550	***	*	39.2163	*	*	39.2163
050551	1.3889	1.2002	37.6223	39.4047	42.2041	39.7598
050552	0.9442	1.2002	35.3468	38.6658	41.1173	38.3633
050557	1.6479	1.2002	39.2224	41.9292	43.9916	41.7837
050561	1.3989	1.2002	40.1567	43.1147	46.9113	43.3701
050567	1.5237	1.2002	39.0114	41.7247	46.3879	42.4571
050568	1.1903	1.2002	26.7733	28.7691	30.1104	28.6056
050570	1.7113	1.2002	40.6761	40.3411	42.9671	41.3473
050573	1.6162	1.2002	36.8561	38.0175	41.0463	38.7328
050575	1.5692	1.2002	22.1018	32.1046	33.5745	29.0057
050578	***	*	43.4917	*	*	43.4917
050580	1.3315	1.2002	35.0966	36.7968	33.1767	35.0893
050581	1.6333	1.2002	40.0909	41.9698	45.2924	42.4394
050583	***	*	40.5845	41.3920	*	40.9835
050584	***	*	31.9910	30.8650	*	31.4271
050586	1.6278	1.2002	31.1932	32.7348	32.8095	32.2361
050588	1.4763	1.2002	39.4251	39.0347	41.0641	39.8351
050589	1.2827	1.2002	37.2056	39.2646	40.8842	39.1776
050590	1.4972	1.3217	44.3382	50.0371	49.7328	48.1461
050592	***	*	32.2376	*	*	32.2376
050597	1.4581	1.2002	32.8987	35.6567	37.5208	35.3960
050599	2.0012	1.3217	36.6146	38.9877	39.8105	38.5379
050601	***	*	43.2404	43.3329	46.0784	44.2186
050603	1.5047	1.2002	35.4809	37.4348	38.3834	37.1447
050604	1.6291	1.6059	49.6068	54.1687	55.6773	53.0805
050608	1.3872	1.2002	30.7280	28.3794	30.7212	29.9386
050609	1.4301	1.2002	43.4555	45.2475	49.1701	45.9890
050616	1.4949	1.2002	40.7388	45.2614	43.3018	43.0759
050618	0.9683	1.2002	34.9177	34.0584	35.2789	34.7493
050624	1.5075	1.2002	39.2553	40.2253	41.9206	40.5628
050625	1.8425	1.2002	44.8482	48.1826	46.7270	46.6153
050633	1.2030	1.2121	40.7383	41.1786	44.7463	42.2532
050636	1.4438	1.2002	35.4565	38.8844	39.6096	38.0088

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050641	1.3049	1.2002	32.0508	33.1417	34.1849	33.1406
050644	1.0475	1.2002	33.2777	32.1513	32.5153	32.6132
050660	1.6423	*	*	*	*	*
050662	1.1129	1.6059	*	*	*	*
050663	1.3695	1.2002	17.7252	30.4117	33.0151	26.4022
050667	0.8006	1.4010	25.8460	30.1039	32.0624	28.9596
050668	1.0786	1.5428	52.7011	62.7714	65.4231	60.6295
050674	1.4993	1.3217	48.6880	51.3517	53.4854	51.2273
050677	1.5581	1.2002	41.8130	44.4567	47.7267	44.6382
050678	1.4527	1.2002	35.8411	38.3361	39.9167	38.1597
050680	1.4613	1.5428	39.0389	40.7514	44.0282	41.3411
050682	0.6944	1.2002	22.3903	22.4419	*	22.4133
050684	1.2570	1.2002	33.5915	33.0982	35.4682	34.0341
050686	1.3750	1.2002	42.1444	45.2231	48.0040	45.1124
050688	1.3358	1.6059	53.2741	54.5423	56.6466	54.9010
050689	1.5695	1.5536	48.9935	50.2942	53.7493	51.0590
050690	1.3287	1.5428	51.6179	55.1002	55.3847	54.0619
050693	1.4804	1.2002	42.8266	41.9594	44.4380	43.0972
050694	1.2375	1.2002	34.8486	33.8553	35.2422	34.6536
050696	2.5549	1.2002	39.4353	41.2315	44.0844	41.4935
050697	1.1148	1.3277	26.7600	29.0854	30.2726	28.7053
050701	1.3546	1.2002	37.2839	38.4382	42.7575	39.6135
050704	1.1342	1.2002	32.2017	31.7051	32.1670	32.0293
050707	***	*	44.0254	49.4684	*	46.9800
050708	1.8358	1.2002	28.3074	34.4063	34.8907	31.9717
050709	1.6404	1.2002	29.5364	30.4570	28.8514	29.5817
050710	1.4205	1.2002	46.2533	51.1460	52.8041	50.0857
050714	1.5922	1.6059	42.9797	45.2746	47.4228	45.3980
050717	1.5965	1.2002	37.0875	42.2736	41.8557	40.5623
050720	***	*	32.1173	33.8712	34.7221	33.4577
050722	0.9563	1.2002	35.6741	35.2177	37.3302	36.1210
050723	1.5436	1.2002	42.1571	43.3875	47.0388	44.1779
050724	1.9468	1.2002	35.1020	35.5224	39.0539	36.5017
050725	0.9517	1.2002	28.8389	27.8565	*	28.3307
050726	1.6175	1.2002	30.6105	35.3964	36.4404	34.1918
050727	1.3740	1.2002	33.0932	29.0789	35.3258	32.5219
050732	2.3923	1.2002	34.3475	37.4333	37.9684	36.6936

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050733	1.7727	1.3277	40.6320	44.7509	44.5719	43.2177
050735	1.4534	1.2002	36.6081	34.3859	34.2886	35.0721
050736	1.3576	1.2002	41.8938	38.0913	36.6220	38.8361
050737	1.7443	1.2002	38.0424	36.4535	38.0483	37.5164
050738	1.6053	1.2002	43.9259	40.3081	39.1266	41.0361
050739	1.6999	1.2002	57.2480	44.0540	40.0074	45.3865
050740	1.7415	1.2002	54.0370	44.8439	37.0976	43.5160
050741	***	*	51.1526	44.0305	*	47.5915
050742	1.6473	1.2002	39.2532	41.0036	44.3972	41.4615
050744	1.7380	1.2002	48.4951	56.5911	54.9148	53.1646
050745	1.4481	1.2002	42.5523	48.2903	48.8922	46.5732
050746	1.8123	1.2002	43.2015	46.3622	45.1988	44.9325
050747	1.8632	1.2002	44.5887	47.8242	47.3968	46.5482
050748	1.2527	1.2002	43.1008	50.6390	54.1242	49.3277
050749	1.3796	1.2002	28.2000	39.6030	41.4811	35.7689
050750	***	*	33.9915	*	*	33.9915
050751	3.5931	1.2002	29.5488	34.0436	36.5150	33.0527
050752	1.4901	1.2002	39.8035	41.3783	42.4687	41.1950
050754	1.2220	1.5182	*	56.3628	*	56.3628
050755	1.6182	1.2002	*	36.5212	36.5251	36.5232
050756	***	*	*	33.4951	*	33.4951
050757	1.7470	1.2002	*	*	42.3546	42.3546
050758	1.5779	1.2002	*	17.6509	27.8366	21.8706
050759	***	*	*	*	36.7495	36.7495
050760	1.3958	1.5536	*	*	*	*
050761	1.6126	1.2002	*	*	*	*
050762	1.4125	1.2002	*	*	*	*
050763	0.9992	1.2002	*	*	*	*
050764	1.6615	1.3277	*	*	*	*
050765	1.1291	1.2002	*	*	*	*
050766	1.5412	1.2002	*	*	*	*
060001	1.4318	1.0303	32.4226	32.5239	33.5009	32.8211
060003	1.5346	1.0303	31.8637	33.6264	34.9819	33.5098
060004	1.2485	1.0485	34.8428	34.5727	36.3214	35.2917
060006	1.2988	0.9581	27.6453	30.5664	30.7361	29.6331
060008	1.5166	0.9581	27.2071	26.0851	28.6913	27.3573
060009	1.6004	1.0485	34.0151	35.8398	36.9037	35.5950

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
060010	1.5399	0.9581	30.6424	33.5549	32.9241	32.3981
060011	1.5301	1.0485	34.4171	34.6239	36.6800	35.2356
060012	1.5328	0.9581	29.4365	29.6957	31.4807	30.2506
060013	1.6156	0.9581	28.0800	29.5100	30.9706	29.5285
060014	2.0318	1.0485	33.0366	35.6231	36.9360	35.1981
060015	2.1471	1.0485	36.3296	36.6824	38.2231	37.1141
060016	1.1827	0.9581	28.3055	30.0601	30.4208	29.6098
060018	1.0992	*	26.5788	*	*	26.5788
060020	1.6397	0.9581	26.7362	27.3823	29.0073	27.7438
060022	1.6431	0.9581	31.9376	32.0594	31.6915	31.8828
060023	1.6909	1.0303	32.7922	33.4798	34.9894	33.7723
060024	1.9110	1.0485	32.8206	36.1736	37.9233	35.6626
060027	1.5428	1.0303	31.6134	33.4869	33.6616	32.8750
060028	1.6913	1.0485	33.4966	35.8222	37.1167	35.5436
060030	1.4475	0.9581	31.2932	31.2752	32.9330	31.8568
060031	1.5069	1.0303	30.7381	32.0153	33.2299	32.0027
060032	1.6656	1.0485	34.6447	35.6500	37.4582	35.9181
060034	1.8224	1.0485	33.3656	34.6615	36.1706	34.7283
060036	1.1704	0.9581	20.9370	24.8220	25.3568	23.6418
060041	***	*	31.4739	*	*	31.4739
060043	0.8976	0.9581	23.3908	19.9611	20.3282	21.2601
060044	1.2481	0.9581	28.9200	32.0455	32.7653	31.1835
060049	1.4153	0.9581	32.1589	34.5262	35.5353	34.0821
060054	1.4909	1.0051	24.6721	29.2998	32.8197	29.3593
060064	1.8838	1.0485	37.2407	34.7448	36.3099	36.0591
060065	1.4593	1.0485	34.9205	36.2377	37.7892	36.3163
060071	1.1608	0.9581	31.5388	32.1367	32.4497	32.0600
060075	1.4614	1.0051	35.8081	37.3019	40.1016	37.8404
060076	1.3290	0.9581	31.6044	31.5032	31.8373	31.6524
060096	1.8302	1.0303	38.2249	39.9302	42.6189	40.4330
060100	1.7950	1.0485	33.5356	35.7861	36.6803	35.3368
060103	1.4229	1.0303	33.7542	34.9964	36.7528	35.2095
060104	1.5478	1.0485	37.1434	37.4598	39.0604	37.9751
060107	2.0677	1.0485	30.3991	30.0308	30.5898	30.3552
060112	1.7503	1.0485	35.1308	36.4093	37.9928	36.6034
060113	1.5005	1.0485	35.2097	36.0794	38.0309	36.4956
060114	1.6645	1.0485	35.3056	37.1394	37.6554	36.8077

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
060115	0.9083	0.9581	*	*	*	*
060116	1.4913	1.0303	33.1547	36.3560	36.9071	35.6457
060117	1.3581	0.9581	28.3112	31.6734	31.3013	30.6152
060118	1.4926	1.0303	*	40.2136	39.9922	40.0904
060119	1.9646	0.9581	*	*	34.0822	34.0822
060121	2.1298	1.0303	*	*	38.3284	38.3284
060123	1.8589	1.0485	*	*	*	*
070001	1.6363	1.2234	37.9438	38.4864	39.3014	38.5781
070002	1.7996	1.1251	36.4269	36.6624	39.3490	37.4818
070003	1.1819	1.1251	36.0524	36.6553	37.6699	36.7817
070004	1.1875	1.1251	31.2115	34.3803	35.1037	33.5419
070005	1.6586	1.2234	36.5502	37.3430	38.3363	37.4209
070006	1.6560	1.2817	41.2165	41.9550	43.2602	42.1481
070007	1.4209	1.1353	37.0984	38.9830	40.3319	38.8215
070008	1.3351	1.1251	35.4969	34.0603	35.8161	35.1073
070009	***	*	36.6382	38.1380	*	37.4141
070010	1.6960	1.2817	38.6114	38.7345	41.3102	39.5949
070011	1.4801	1.1251	32.6835	33.7313	36.9466	34.4150
070012	1.4730	1.1251	33.2477	35.4738	37.5683	35.3833
070015	1.5810	1.2817	39.9249	42.4738	43.1481	41.8469
070016	1.5918	1.2234	34.1266	34.5418	36.2707	34.9884
070017	1.4503	1.2234	37.5855	38.1713	41.0077	38.9339
070018	1.4031	1.2817	42.4771	44.1370	45.8974	44.2078
070019	1.5997	1.2234	35.8618	37.0666	39.8743	37.6317
070020	1.3867	1.1352	35.6542	40.4989	40.6182	39.0618
070021	1.1794	1.1251	39.7793	41.9076	43.8622	41.8599
070022	1.7333	1.2234	41.4721	41.5553	43.2394	42.1299
070024	1.5050	1.1353	36.8997	38.6301	39.2511	38.2737
070025	1.7003	1.1251	36.1322	38.7067	38.9328	37.9080
070027	1.5868	1.1251	33.5979	35.7677	36.5223	35.3536
070028	1.5644	1.2817	40.9645	41.2950	42.0488	41.4517
070029	1.3443	1.1251	32.8504	35.4716	36.0406	34.8141
070031	1.3419	1.2234	30.5924	33.2618	33.5139	32.4882
070033	1.4782	1.2817	44.6717	46.5982	47.7688	46.3583
070034	1.5225	1.2817	42.4111	45.7694	44.0374	44.0855
070035	1.4095	1.1251	33.4047	38.2298	35.3357	35.6697
070036	1.7475	1.1654	43.6374	44.0756	46.4609	44.7773

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
070038	0.9441	1.2234	29.9516	33.5109	31.4454	31.4773
070039	1.0971	1.2234	32.7153	35.9137	36.2927	35.1271
070040	1.0743	1.1251	*	26.3824	30.5486	28.3408
080001	1.6907	1.0802	34.9507	37.4441	39.1835	37.2540
080002	***	*	33.0404	33.3472	35.2276	33.8892
080003	1.5403	1.0802	30.5132	29.0166	31.5225	30.4059
080004	1.6748	1.0690	34.3854	33.6190	35.0266	34.3423
080006	1.5520	1.0090	31.0327	30.7985	29.2411	30.3636
080007	1.7565	1.0903	33.4782	35.5425	37.5631	35.5927
090001	1.7104	1.0561	40.1658	38.3876	39.8134	39.3691
090003	1.3090	1.0561	34.4430	37.2088	37.3982	36.3730
090004	2.0589	1.0573	38.5681	39.9027	40.6216	39.7496
090005	1.3805	1.0561	35.2884	35.1327	36.9545	35.7927
090006	1.4341	1.0561	32.3654	32.5988	34.9946	33.3147
090008	1.5880	1.0561	36.6633	40.3260	41.7318	39.2644
090011	2.1681	1.0561	39.0111	39.5389	41.3036	39.9493
100001	1.6225	0.8902	27.8526	30.5213	30.2446	29.5877
100002	1.5581	1.0364	30.6668	33.1103	34.4039	32.7223
100006	1.6837	0.9178	28.9769	29.2697	31.1090	29.8250
100007	1.6560	0.9178	30.3379	30.6689	32.7648	31.2751
100008	1.6404	1.0222	32.1679	32.3397	34.9341	33.1587
100009	1.6764	1.0222	30.0492	32.0145	33.5623	31.8710
100012	1.6726	0.9167	30.8626	30.2066	32.0081	31.0290
100014	1.5567	0.9178	27.4064	28.8679	32.2443	29.5972
100015	***	*	28.6825	29.9757	31.5936	30.0347
100017	1.6037	0.9178	29.8705	31.2313	32.0601	31.0930
100018	1.7857	0.9809	32.8642	34.2077	34.9524	34.0313
100019	1.7306	0.9332	31.4549	32.2496	34.2627	32.6917
100022	1.7695	1.0364	36.3355	40.4664	42.4881	39.7952
100023	1.6827	0.9094	27.1032	27.7860	27.8953	27.6060
100024	1.2216	1.0222	29.8918	31.5160	30.5545	30.6338
100025	1.8056	0.8458	27.1665	28.7604	29.6928	28.5823
100026	1.6151	0.8458	27.3044	28.5877	27.8367	27.9162
100028	1.4448	0.9332	28.7801	28.1509	31.9846	29.6732
100029	1.3707	1.0222	31.6006	33.2920	34.8161	33.2424
100030	1.4694	0.9178	26.3113	27.0977	30.8824	28.0853
100032	1.7391	0.9094	27.8942	29.3641	30.3253	29.1887

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100034	1.8674	1.0222	28.9387	29.8997	29.6114	29.4885
100035	1.5772	0.9265	32.5593	31.2325	31.4578	31.7203
100038	1.6264	1.0364	32.8392	37.0928	37.1884	35.7516
100039	1.9693	1.0364	29.0236	32.6863	32.2419	31.3704
100040	1.7070	0.8902	28.3366	29.8029	29.6297	29.2510
100043	1.4166	0.9094	26.8417	29.1014	31.1972	28.9417
100044	1.5653	1.0762	34.3920	34.4743	41.7922	37.0061
100045	1.3103	0.9178	25.5621	27.8526	28.1643	27.2127
100046	1.5558	0.9094	27.7878	29.7844	30.9730	29.5992
100047	1.6811	0.9265	31.4072	31.8998	32.2047	31.8452
100048	0.9614	0.8458	21.7693	22.7260	23.5379	22.6813
100049	1.3320	0.8628	27.6316	26.9145	27.7020	27.4184
100050	1.2458	1.0222	23.5222	23.7419	24.5868	23.9540
100051	1.4875	0.9178	30.1492	28.7367	30.6461	29.8530
100052	1.4003	0.8628	25.1110	27.6591	28.4807	27.1112
100053	1.4162	1.0222	31.9268	33.6936	35.2550	33.5895
100054	1.4027	0.8762	30.9840	33.2237	36.2168	33.5037
100055	1.4759	0.9094	29.7027	28.5830	30.4298	29.5982
100057	1.4780	0.9178	27.7045	30.4258	30.5235	29.5810
100061	1.5789	1.0222	31.9174	33.9803	34.8482	33.5811
100062	1.7148	0.8578	26.3067	28.0821	29.2949	27.9112
100063	1.4087	0.9094	27.0769	29.5864	31.2488	29.3363
100067	1.5488	0.9094	27.5501	30.0555	31.5618	29.6772
100068	1.7784	0.9178	27.7707	28.5177	28.0307	28.1041
100069	1.8450	0.9094	29.0486	33.4008	32.7796	31.7251
100070	1.6892	0.9265	29.1117	27.1313	27.9973	28.0427
100071	1.3529	0.9094	25.1883	25.6870	27.8655	26.2748
100072	1.4518	0.9178	27.6947	28.6435	29.6882	28.7088
100073	1.7399	1.0364	31.0395	33.8783	33.7457	32.8947
100075	1.5788	0.9094	26.7571	29.2992	31.2004	29.0714
100076	1.2234	1.0222	24.0280	23.7078	26.3433	24.4935
100077	1.3992	0.9265	27.9783	28.0178	29.5962	28.5634
100079	1.5106	*	*	*	*	*
100080	1.6204	1.0364	31.0516	33.2091	35.4485	33.2130
100081	1.0281	0.8565	19.7406	17.2548	17.7222	18.2774
100084	1.6551	0.9178	30.6301	30.7165	35.1858	32.1812
100086	1.5751	1.0364	31.3187	33.0726	33.7048	32.7154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100087	1.8405	0.9265	32.1314	33.4104	33.2328	32.9255
100088	1.7052	0.8902	29.4952	30.3481	30.9148	30.2877
100090	1.4563	0.8902	28.9581	27.4996	28.2012	28.2140
100092	1.5558	0.9332	28.6782	29.1433	29.6087	29.1462
100093	1.7452	0.8458	23.4847	24.9505	25.8345	24.7522
100099	1.1448	0.8628	28.0688	28.2871	30.0337	28.8423
100102	1.0551	0.8458	29.0396	30.0754	28.5248	29.1936
100105	1.5943	1.0283	30.8936	31.5294	33.0707	31.8950
100106	1.0979	0.8458	25.6288	20.6449	26.2560	24.0768
100107	1.2712	0.9167	31.2954	30.9662	32.4297	31.5714
100108	***	*	22.8153	17.9561	17.5426	19.1444
100109	1.3854	0.9178	26.7380	29.1403	29.2478	28.3934
100110	1.6147	0.9178	30.3758	32.4083	32.8616	31.9067
100113	2.0648	0.9406	30.6037	30.9741	33.2418	31.6327
100114	***	*	32.3956	34.3630	*	33.3214
100117	1.1720	0.8902	30.0281	30.6894	31.4492	30.7465
100118	1.4486	0.8458	28.3201	31.3833	28.6480	29.3969
100121	1.1958	0.8628	25.0320	20.0814	27.6294	24.2372
100122	1.2388	0.8762	27.6178	27.9970	28.5222	28.0534
100124	1.1993	0.8458	26.2329	28.2667	28.9298	27.8069
100125	1.2299	1.0222	33.3499	35.2588	37.2705	35.4531
100126	1.3809	0.9094	28.9164	30.3912	31.2105	30.1653
100127	1.6431	0.9094	27.0686	29.3856	31.1177	29.1793
100128	2.2037	0.9094	30.6202	29.6793	31.2298	30.5186
100130	1.3212	1.0364	29.5763	29.9727	29.8339	29.7970
100131	1.3800	1.0222	30.9614	32.2086	33.9594	32.3908
100132	1.3499	0.9094	27.6632	29.3380	30.9567	29.3475
100134	0.8526	0.8458	22.9635	24.7863	23.0684	23.5589
100135	1.6829	0.8981	29.8452	30.2093	34.2492	31.4439
100137	1.4023	0.8628	28.3000	27.8783	28.6777	28.2947
100139	0.9036	0.9406	21.4418	22.1683	21.4572	21.6824
100140	1.1241	0.8902	28.5485	29.7482	30.7155	29.6963
100142	1.2138	0.8458	26.8995	26.8829	25.1309	26.3144
100150	1.2062	1.0222	29.3711	33.0132	32.5785	31.6449
100151	1.9703	0.8902	31.3846	33.1725	34.9557	33.1543
100154	1.7005	1.0222	31.3640	32.3793	34.9899	32.9507
100156	1.1212	0.8458	28.3060	29.9029	31.1552	29.8254

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100157	1.5825	0.9094	30.3359	30.4870	31.8594	30.8981
100160	1.1017	1.0222	32.3136	33.8433	35.2448	33.8503
100161	1.6418	0.9178	30.8984	32.6427	33.0240	32.1874
100166	1.6290	0.9265	31.9072	33.0019	34.8424	33.2088
100167	1.5548	1.0364	32.4740	34.8085	36.1348	34.4179
100168	1.7112	1.0364	28.0543	31.1427	32.5053	30.6385
100172	***	*	20.5518	*	*	20.5518
100173	1.7179	0.9094	30.2491	30.3599	30.9982	30.5313
100175	1.0188	0.8458	26.1723	26.8828	30.6970	27.8555
100176	1.7599	1.0364	35.5849	35.7433	37.0046	36.1156
100177	1.4618	0.9332	31.0085	31.3830	32.8491	31.7568
100179	1.7363	0.8902	30.5439	31.8790	33.3430	31.9272
100180	1.4792	0.9094	31.5485	32.3796	34.6817	32.8425
100181	1.4002	1.0222	26.0682	26.0880	26.4568	26.2189
100183	1.3902	1.0222	32.9893	31.6760	33.2466	32.6280
100187	1.4893	1.0222	31.6660	31.8020	34.2328	32.5967
100189	1.4419	1.0364	30.5516	32.8847	34.2447	32.5432
100191	1.3645	0.9094	30.9212	31.6024	33.7871	32.0675
100200	1.5295	1.0364	29.0731	32.5611	33.7050	31.7495
100204	1.6164	0.9406	29.9334	30.6252	31.4765	30.6899
100206	1.3259	0.9094	28.8625	30.4576	31.2653	30.2061
100209	1.6863	1.0222	29.0462	30.5582	32.8523	30.8033
100210	1.6173	1.0364	32.4566	33.3016	34.2993	33.3096
100211	1.2867	0.9094	28.8328	30.5902	31.6079	30.3679
100212	1.5679	0.8578	29.2500	30.5141	31.1368	30.3163
100213	1.5727	0.9265	30.2271	31.4309	33.1230	31.5995
100217	1.2905	1.0283	30.3325	33.5767	30.5641	31.4346
100220	1.6269	0.9167	30.8292	31.8393	33.1625	32.0038
100223	1.6223	0.8762	27.6775	28.6449	30.3741	28.8695
100224	1.3813	1.0364	29.2008	31.0307	33.6361	31.2128
100225	***	*	32.6906	31.8048	*	32.2587
100226	1.3734	0.8902	30.2857	30.8904	31.4361	30.8818
100228	1.4519	1.0364	31.0222	32.2672	34.6713	32.6412
100230	1.4348	1.0364	34.6133	35.9319	36.1673	35.6194
100231	1.6148	0.8458	28.3652	28.8912	29.8895	29.0352
100232	1.4309	0.9406	29.3797	30.3768	30.7940	30.1690
100234	1.3292	1.0364	29.7818	33.1508	35.3677	32.6857

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100236	1.4897	0.9265	30.5719	31.4385	33.2992	31.8165
100237	***	*	33.9626	33.9696	34.7138	34.1878
100238	1.6561	0.9094	31.6353	32.8745	35.1867	33.2711
100239	1.5075	0.9094	30.3234	32.7150	33.9579	32.2861
100240	1.1030	1.0222	31.0951	35.3888	36.6032	34.5027
100242	1.5952	0.8458	27.8169	28.5034	29.7347	28.6980
100243	1.5542	0.9094	29.8323	31.4863	32.5227	31.3056
100244	1.4331	0.9167	29.8287	29.1611	30.3453	29.7743
100246	1.5614	1.0762	30.0467	32.5063	33.5469	32.0515
100248	1.5668	0.9094	32.4725	33.7659	36.0601	34.0862
100249	1.3514	0.9094	28.5117	29.7981	30.5240	29.6388
100252	1.2169	1.0283	29.1448	31.5631	33.8245	31.4852
100253	1.4998	1.0364	28.5617	29.4959	31.3059	29.8138
100254	1.5108	0.8981	28.5262	28.9095	30.8142	29.4282
100255	1.3545	0.9094	29.5172	30.0466	31.9271	30.4950
100256	1.6224	0.9094	33.3936	34.6637	34.8304	34.2928
100258	1.6613	1.0364	35.2225	34.2862	36.3146	35.2877
100259	1.2922	0.9094	29.9294	32.2273	33.8210	31.9723
100260	1.5192	1.0762	29.4907	31.5667	33.8328	31.6747
100264	1.5444	0.9094	30.1980	31.5050	33.9279	31.9530
100265	1.4504	0.9094	26.6940	28.6915	30.9790	28.8513
100266	1.4224	0.8458	25.6382	26.4488	27.7418	26.6590
100267	1.2849	0.9265	30.6051	32.3955	33.7231	32.2103
100268	1.2089	1.0364	33.6225	33.5314	34.5858	33.9080
100269	1.4107	1.0364	28.3745	30.9572	33.5064	30.8897
100271	2.2229	*	*	*	*	*
100275	1.3264	1.0364	31.0487	31.5424	33.3199	32.0064
100276	1.3326	1.0364	31.7067	32.3992	34.3287	32.8345
100277	1.3799	1.0222	25.5926	27.0942	28.4949	27.0616
100279	***	*	31.1951	31.6691	33.9735	32.3443
100281	1.4063	1.0364	32.8840	36.3173	36.3681	35.2827
100284	1.1512	1.0222	21.4420	24.4155	25.5819	23.7595
100285	1.2393	1.0364	34.7999	36.2107	37.2874	36.2349
100286	1.6176	0.9809	26.5809	26.1494	32.3293	29.0001
100287	1.4754	1.0364	30.3085	32.3704	34.0899	32.1810
100288	1.7381	1.0364	32.9587	35.3363	36.0630	34.7728
100289	1.5892	1.0364	31.4727	31.7699	33.2012	32.2125

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100290	1.2699	0.9178	29.7588	31.7110	32.8039	31.5893
100291	1.2805	0.9332	28.3780	28.3455	28.7323	28.4870
100292	1.4540	0.8565	28.5807	29.8156	30.8473	29.8365
100296	1.4038	1.0222	31.1475	31.8730	34.2725	32.5067
100298	0.8558	0.8981	21.9247	17.8678	19.4952	19.4589
100299	1.4576	0.9265	31.6840	31.5048	31.4297	31.5278
100300	***	*	33.1693	*	*	33.1693
100301	***	*	*	33.6261	*	33.6261
100302	1.1221	0.9178	*	27.9362	29.7289	28.8052
100303	***	*	*	*	24.9650	24.9650
100307	1.5052	0.8902	*	*	*	*
100308	1.8792	0.9094	*	*	*	*
100309	2.7432	0.9824	*	*	*	*
100310	3.4842	0.9824	*	*	*	*
100311	2.4626	0.9094	*	*	*	*
110001	1.4636	0.8602	27.6480	28.5465	29.5684	28.6101
110002	1.3129	0.8970	28.9013	32.2910	31.4618	30.8489
110003	1.3324	0.7782	25.0089	26.0330	25.4762	25.5083
110004	1.3418	0.8794	27.2528	26.8828	29.0667	27.7197
110005	1.4382	0.9572	29.6009	30.4924	30.9276	30.4128
110006	1.6178	0.9348	30.8495	32.2597	34.4102	32.5400
110007	1.7505	0.9098	28.0684	29.8618	31.7901	29.9011
110008	1.4810	0.9572	31.8387	33.5616	31.8787	32.4273
110010	2.4555	0.9572	33.9848	33.7073	37.5179	35.0462
110011	1.4340	0.9572	30.3534	32.2028	34.6167	32.4547
110015	1.0789	0.9572	30.5016	31.7245	32.9437	31.7570
110016	1.3214	0.8621	25.9209	26.3449	27.9587	26.7064
110018	1.4095	0.9572	30.9422	30.8295	32.9879	31.5762
110020	***	*	29.4641	30.4725	31.6465	30.4885
110023	1.4384	0.9572	29.2018	31.1890	31.5376	30.6943
110024	1.5142	0.8858	28.5660	30.7207	31.0718	30.1390
110025	1.4691	0.9352	31.8968	31.0532	32.4958	31.8053
110026	1.1774	0.7782	24.3863	25.6943	25.5958	25.1969
110027	1.0792	0.7782	25.6532	26.2689	26.5342	26.1268
110028	1.8270	0.9571	32.8706	34.0699	34.0976	33.6914
110029	1.8427	0.9572	30.1146	31.6425	33.8978	31.8764
110030	1.4738	0.9572	32.0275	33.2158	35.3984	33.6145

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110031	1.2980	0.9572	30.7462	30.4811	31.6496	30.9694
110032	1.2257	0.7782	24.4968	23.1156	25.3848	24.3265
110033	***	*	32.7039	31.9373	*	32.3312
110034	1.8212	0.9571	29.6819	30.4053	34.1394	31.4559
110035	1.6957	0.9572	31.5737	31.8545	33.7827	32.4229
110036	1.9192	0.8858	28.4041	29.4915	30.6530	29.5209
110038	1.6353	0.7840	23.3669	24.2742	26.0470	24.6113
110039	1.3610	0.9571	28.4376	28.9594	29.2688	28.9113
110040	1.0861	0.9572	21.5762	21.1939	23.4093	22.0778
110041	1.4490	0.9348	27.6609	29.2068	29.6983	28.8467
110042	1.0433	0.9572	34.5137	34.0568	35.6003	34.7521
110043	1.8463	0.8858	30.3728	31.1628	31.4697	31.0207
110044	1.1492	0.7782	27.0431	25.0449	25.2725	25.8029
110045	1.0749	0.9572	28.2232	31.6766	31.6090	30.4800
110046	1.1860	0.9572	28.6286	28.4212	30.3845	29.1786
110050	1.0846	0.8483	27.1533	29.2759	30.0217	28.7933
110051	1.1636	0.7782	22.1491	23.3866	25.5805	23.8633
110054	1.5235	0.9572	31.5798	27.9775	28.7220	29.3745
110059	1.1670	0.7782	24.9271	24.4436	25.3086	24.8831
110064	1.7636	0.9119	28.7296	30.0182	33.6996	30.7770
110069	1.4012	0.8970	30.6465	31.0168	29.2608	30.2522
110071	1.0603	0.7782	23.6499	22.6384	22.8137	23.0100
110073	1.1093	0.7782	23.0072	23.4570	24.6046	23.6849
110074	1.6250	0.9348	29.0310	30.4310	32.0070	30.5025
110075	1.3248	0.8858	26.1089	26.7302	27.8478	26.9319
110076	1.6273	0.9572	31.0661	30.4815	31.6821	31.0859
110078	2.1377	0.9572	32.0516	35.8457	34.2909	34.0297
110079	1.5730	0.9572	29.0905	28.9872	29.4495	29.1738
110082	2.0493	0.9572	31.1478	33.1144	35.7031	33.2771
110083	2.0957	0.9572	34.5798	34.7446	35.7676	35.0417
110086	1.3316	0.7782	23.4772	23.1298	23.4255	23.3429
110087	1.6146	0.9572	32.8029	33.9036	33.1508	33.2981
110089	1.0939	0.7782	26.0116	25.4960	27.7584	26.4217
110091	1.4186	0.9572	28.0637	29.4898	30.4058	29.2918
110092	1.1014	0.7782	22.8602	24.5262	28.2182	24.9164
110095	1.4911	0.8547	28.0480	31.2298	30.8338	30.0970
110100	0.9291	0.8572	20.0638	22.9014	22.3608	21.8873

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110101	1.0901	0.7849	23.8601	25.5998	27.0115	25.5015
110104	1.2299	0.7782	22.2596	22.3707	22.3377	22.3206
110105	1.3045	0.8547	23.7752	24.6128	25.9808	24.8167
110107	1.9862	0.9368	31.5783	34.3508	31.8817	32.6134
110109	0.9841	0.7782	21.6019	22.5719	24.1377	22.7275
110111	1.2997	0.9571	27.6501	25.7188	26.1218	26.4751
110112	1.0053	0.8547	24.2935	23.2426	23.9046	23.7940
110113	0.9056	0.9571	22.0472	24.2980	23.8703	23.3793
110115	1.8784	0.9572	33.3902	34.4864	35.7096	34.5483
110121	1.0235	0.7782	24.5653	27.4406	28.0044	26.6723
110122	1.5890	0.8795	26.3071	28.0334	29.0791	27.8028
110124	0.9766	0.7782	24.8552	28.7544	30.2200	27.9406
110125	1.3181	0.8970	26.5006	29.4103	30.8516	28.8615
110128	1.3499	0.7782	24.5284	27.1987	29.1767	26.8886
110129	1.6241	0.9119	29.7332	26.8229	29.6690	28.7891
110130	0.8616	0.7782	21.7089	21.0352	21.7302	21.5091
110132	0.9942	0.7782	21.6039	22.3816	23.0261	22.3425
110135	1.4233	0.7782	25.1027	25.6594	25.4541	25.3958
110142	0.9519	0.7967	22.2164	21.2836	23.4220	22.2520
110143	1.4910	0.9572	30.9621	31.3623	33.8251	32.0572
110146	0.9949	0.9352	30.1181	32.7307	33.2928	32.0816
110150	1.3556	0.8970	27.7920	28.7549	25.9718	27.3903
110153	1.2669	0.8970	30.5108	30.2843	29.0378	29.9181
110161	1.6539	0.9572	32.0002	32.9894	34.2402	33.1043
110163	1.5743	0.9098	29.5693	30.7798	31.5968	30.6951
110164	1.7796	0.9368	31.2830	32.7865	34.6876	32.9571
110165	1.5814	0.9572	28.7925	28.4324	29.6512	28.9468
110168	1.8987	0.9572	30.8750	31.8921	32.9718	31.9136
110172	***	*	33.0452	34.0243	*	33.5073
110177	1.9707	0.9571	30.5526	31.9338	34.1139	32.1851
110183	1.3243	0.9572	29.6622	32.0200	32.3945	31.3716
110184	1.2816	0.9572	30.2920	30.8380	33.5282	31.6112
110186	1.3175	0.9119	29.6503	32.0599	32.7164	31.3889
110187	1.2145	0.9572	31.0164	27.6729	30.2062	29.5462
110189	1.0743	0.9572	27.4207	28.9465	30.6935	29.0587
110190	1.0617	0.8470	29.4198	28.7747	35.0710	30.9664
110191	1.4803	0.9572	28.7505	30.0142	32.1599	30.3011

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110192	1.5471	0.9572	31.6627	32.6403	33.8949	32.7867
110194	0.8287	0.7782	20.5267	23.2382	22.8941	22.2276
110198	1.4509	0.9572	34.0050	33.2450	34.3576	33.8700
110200	2.3051	0.9119	29.4633	29.6256	31.9920	30.3302
110201	1.5909	0.9368	33.4292	35.8335	37.5429	35.6404
110203	1.0033	0.9572	32.0594	33.0119	39.2026	34.2394
110205	1.1254	0.8289	26.1973	25.5319	25.5795	25.7616
110209	0.8544	0.7782	22.4549	21.6681	24.1927	22.7937
110212	1.1580	0.8131	*	23.4398	24.7805	24.1197
110215	1.5772	0.9572	30.1793	31.2779	34.0438	31.9379
110219	1.5092	0.9572	33.4481	34.8875	35.5795	34.5964
110225	1.4407	0.9572	28.9773	29.6272	31.3111	30.0865
110226	1.2984	0.9572	32.1840	30.2150	31.1969	31.1849
110229	1.5914	0.9572	*	*	30.3562	30.3562
110230	1.4559	0.9572	*	*	35.0804	35.0804
110231	2.6459	0.9348	*	*	*	*
120001	1.9654	1.1635	39.0371	39.2838	41.7842	40.0704
120002	1.3903	1.1292	37.7287	38.3420	40.8461	39.0696
120004	1.4516	1.1635	32.5164	33.3874	34.8788	33.5345
120005	1.4037	1.1292	35.1996	38.2915	39.9388	37.8326
120006	1.3827	1.1635	35.7089	37.6360	38.8087	37.4368
120007	1.6959	1.1635	35.0193	34.8231	35.1439	34.9953
120010	2.0707	1.1635	34.3371	37.3680	38.3032	36.3762
120011	1.6395	1.1635	43.7527	45.9848	46.1156	45.3395
120014	1.3862	1.1292	34.2127	38.1372	37.5329	36.5854
120019	1.1857	1.1292	36.1879	37.4564	39.5249	37.7583
120022	1.8805	1.1635	34.9048	35.3877	38.3908	36.2596
120026	1.4967	1.1635	35.8413	38.2128	40.8061	38.3647
120027	1.4876	1.1635	31.8177	32.7112	36.4792	33.4996
120028	1.3976	1.1292	34.6354	34.7783	35.3970	34.9858
130002	1.4862	0.9068	24.3501	26.4728	25.9204	25.6067
130003	1.7141	0.9659	29.8793	31.4275	32.0498	31.1265
130006	1.7583	0.9305	29.0504	30.0002	31.6998	30.3256
130007	1.8904	0.9305	31.2268	33.4536	33.5741	32.8364
130013	1.4315	0.9305	33.8928	33.6160	34.7966	34.1028
130014	1.2836	0.9305	28.2831	29.1200	31.1589	29.5140
130018	1.7913	0.9676	30.2047	31.8735	34.0700	32.0682

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
130024	1.2438	0.8262	25.3197	24.4757	27.9247	25.9223
130025	1.2892	0.7587	23.8592	24.2424	25.4832	24.5583
130028	1.7322	0.9379	29.3374	30.5090	32.7435	30.8806
130049	1.6650	1.0384	29.7211	30.8293	32.3219	31.0108
130062	***	*	28.3419	38.1416	38.2016	35.1513
130063	1.5471	0.9305	27.7697	28.8897	30.6360	29.0590
130065	2.0187	0.9676	25.8998	29.4957	31.7109	28.7350
130066	2.3072	0.9535	28.1502	29.3049	30.2156	29.2289
130067	3.0407	0.9676	26.8285	28.6474	*	27.6699
130068	***	*	*	25.8399	*	25.8399
130069	2.8776	0.9305	*	*	*	*
130070	2.9727	0.9305	*	*	*	*
140001	1.2495	0.8749	23.2233	23.7481	24.5618	23.9087
140002	1.5362	0.9060	29.1097	29.6312	30.7187	29.8279
140007	1.5429	1.0503	32.4449	34.2607	34.4024	33.7444
140008	1.5089	1.0515	32.7618	33.2563	33.8475	33.2685
140010[3]	1.5525	1.0515	39.3727	39.7245	41.6706	40.3259
140B10[3]	***	*	39.3727	39.7245	41.6706	40.3212
140011	1.1871	0.8380	26.2135	27.0019	27.8999	27.0776
140012	1.1826	1.0370	31.9613	33.0198	33.9621	33.0388
140013	1.3956	0.9289	26.4199	28.2787	29.7601	28.1742
140015	1.3818	0.8955	25.2504	25.8304	27.2800	26.1224
140018	1.4659	1.0515	31.5624	31.2535	32.8781	31.9237
140019	0.9025	0.8380	22.2907	22.9179	22.1774	22.4623
140026	1.2390	0.8695	28.1718	28.5497	28.8965	28.5453
140029	1.6147	1.0503	34.8938	37.7285	39.2923	37.4109
140030	1.6091	1.0503	32.1135	32.8927	34.5324	33.1540
140032	1.2724	0.8955	28.5242	28.4605	28.8062	28.6026
140033	0.8477	1.0736	31.4347	32.3417	37.3159	32.3454
140034	1.2373	0.8955	26.7250	27.6121	29.4226	27.8956
140040	1.2933	0.9179	28.5016	30.5814	29.5659	29.5161
140043	1.2977	0.8658	31.3754	34.4429	36.6352	34.1714
140046	1.5473	0.8955	25.7925	26.8384	27.7909	26.8011
140048	1.3808	1.0515	31.6290	34.4373	35.6153	33.9229
140049	1.5889	1.0515	32.0239	33.6104	35.1305	33.5575
140051	1.6022	1.0515	32.6517	32.7898	35.9661	33.8131
140052	1.4729	0.9060	26.7916	27.7932	28.3571	27.6322

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140053	1.8431	0.8948	29.9487	32.7126	32.7073	31.7542
140054	1.5563	1.0515	34.5369	36.9786	37.5300	36.3814
140058	1.2163	0.8948	26.5671	28.6945	29.4589	28.2825
140059	1.1060	0.9060	22.8597	24.6248	27.1293	24.8684
140062	1.4327	1.0515	36.6718	38.3407	40.0353	38.3865
140063	1.5742	1.0515	31.1266	34.4732	34.2888	33.3236
140064	1.2440	0.9179	26.6249	28.5964	28.7175	28.0100
140065	1.5255	1.0515	32.4661	34.3988	34.8576	33.9264
140066	0.8358	0.9060	23.6304	24.3856	25.8813	24.6266
140067	1.8100	0.9289	30.6911	31.9470	33.6485	32.1175
140068	1.3473	1.0515	31.3463	32.8724	34.3346	32.8242
140075	***	*	33.6872	34.9376	37.0601	35.1205
140077	1.1765	0.9060	22.5074	24.2006	27.9915	24.7807
140080	1.6004	1.0515	30.3788	33.0275	33.9568	32.4504
140082	1.6828	1.0515	32.0562	33.4686	33.5580	33.0486
140083	1.0840	1.0515	26.1639	29.5034	26.0278	27.1377
140084	1.4066	1.0736	31.3307	32.1286	34.0802	32.4884
140088	2.0925	1.0515	34.4137	36.6991	39.5656	36.8355
140089	1.1697	0.8380	26.6955	27.5295	28.0437	27.4281
140091	1.7821	1.0161	29.7381	33.7851	35.7416	33.1415
140093	1.3604	0.9722	31.2973	29.3377	33.9418	31.5446
140094	0.7328	1.0515	28.8621	28.0819	31.7652	29.3420
140095	1.3861	1.0515	29.9626	35.7876	34.5168	33.4434
140100	1.5029	1.0736	37.3044	39.0405	53.2763	43.9761
140101	1.2867	1.0503	31.0070	32.4260	33.9464	32.5018
140103	1.1752	1.0515	25.3630	26.4236	27.1901	26.3291
140105	***	*	30.7154	*	*	30.7154
140110	1.0816	1.0370	31.3486	33.7263	37.0537	34.0414
140113	1.5438	1.0161	31.6191	33.2262	34.9622	33.3322
140114	1.5369	1.0515	31.1412	31.7038	31.4289	31.4242
140115	1.1726	1.0515	26.2606	30.2062	33.4032	29.8398
140116	1.4871	1.0515	34.2519	35.6726	37.3731	35.8074
140117	1.6529	1.0515	28.5809	34.6766	33.8389	32.2626
140118	1.5189	1.0515	33.8168	34.9352	35.7829	34.8477
140119	1.9388	1.0515	34.6543	35.5146	39.1814	36.4476
140120	1.2850	0.9289	26.2418	27.0681	28.1509	27.1802
140122	1.6620	1.0503	32.4750	34.2512	35.7240	34.1638

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140124	1.2545	1.0515	38.8976	39.9267	42.6211	40.3601
140125	1.1748	0.9060	27.6352	28.3533	30.1443	28.6668
140127	1.5604	0.9567	29.3352	30.9124	32.7929	30.9550
140130	1.3285	1.0736	34.9907	35.8275	36.5321	35.7850
140133	1.3550	1.0515	32.8941	34.0222	33.5193	33.4793
140135	1.4489	0.9154	25.9057	26.6854	27.2912	26.6118
140137	1.0866	0.9060	*	27.0616	26.9569	27.0094
140143	1.1048	0.8380	27.0312	27.2878	28.8821	27.7646
140145	1.3204	0.9060	26.9344	28.3622	29.2121	28.2021
140147	1.0814	0.8380	22.1035	22.6508	23.5511	22.7827
140148	1.7060	0.8948	28.9471	30.1467	30.0605	29.7419
140150	1.6603	1.0515	39.0316	41.6125	42.0035	40.9013
140151	0.9472	1.0515	27.3552	28.0758	27.9212	27.7895
140152	***	*	32.2803	*	*	32.2803
140155	1.3206	1.0370	35.0825	36.2360	42.9342	38.0739
140158	1.4480	1.0515	32.0137	31.7570	32.5513	32.1276
140160	1.3230	0.9874	28.9043	30.0100	29.7281	29.5556
140161	1.4829	1.0370	28.8150	33.5158	34.2463	32.1524
140162	1.6404	0.9567	33.0995	33.2372	34.3289	33.5598
140164	1.7410	0.8380	27.3133	27.5981	28.8827	27.9483
140166	1.2438	0.9154	27.6725	27.5406	28.8318	28.0436
140167	1.1637	0.8380	24.2749	21.2479	26.4163	23.8760
140172	1.4264	1.0515	33.4616	36.8394	37.7898	35.9979
140174	1.6817	1.0503	33.9382	35.1535	37.2213	35.4862
140176	1.2563	1.0515	33.2235	34.3901	35.2474	34.3194
140177	1.0534	1.0515	26.0727	28.0720	30.3713	28.2119
140179	1.4032	1.0515	31.3624	30.6997	31.6593	31.2406
140180	1.4341	1.0515	29.8009	31.4683	33.1831	31.5677
140181	1.2767	1.0515	27.5414	29.0862	28.5827	28.4001
140182	1.5270	1.0515	26.4103	34.4971	35.0847	31.5371
140184	1.4579	0.8380	27.5858	28.2155	30.8810	28.8696
140185	1.4880	0.9060	27.9433	29.7742	31.1163	29.6209
140186	1.5823	1.0370	32.8063	32.5128	33.6497	32.9984
140187	1.5586	0.9060	26.9265	29.2345	29.0150	28.4359
140189	1.2512	0.8380	29.1371	25.9192	29.7443	28.2279
140191	1.4166	1.0515	29.7684	31.4076	32.4757	31.2541
140197	1.0537	1.0515	24.8715	26.9930	26.0614	25.9598

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140200	1.5345	1.0503	31.3712	33.2897	34.0868	32.9105
140202	1.4834	1.0736	34.3789	38.4323	37.4214	36.7750
140206	1.1584	1.0515	31.1406	31.5212	27.6427	29.9651
140207	1.2953	1.0515	31.6818	25.8073	32.4874	29.9202
140208	1.8222	1.0515	26.1749	26.2434	36.5625	29.1083
140209	1.6452	0.9289	28.8774	31.5349	31.8673	30.7293
140210	1.0405	0.8380	22.2512	24.1193	24.7376	23.7498
140211	1.4102	1.0503	34.5917	36.0400	37.0954	35.9438
140213	1.2807	1.0503	33.3932	33.6351	35.2016	34.1074
140217	1.5985	1.0503	33.2172	34.8475	36.7916	35.0335
140223	1.6066	1.0515	34.6997	36.6437	38.4099	36.5719
140224	1.4303	1.0515	30.2241	34.4001	32.1594	32.1531
140228	1.4921	1.0052	28.7462	30.7381	33.1724	30.9914
140231	1.5719	1.0503	35.6724	36.3601	38.3032	36.8493
140233	1.7853	1.0052	32.3376	35.7752	36.3886	34.8790
140234	1.0863	0.8695	25.7660	26.9670	27.9382	26.9002
140239	1.7231	1.0052	33.7264	35.6391	35.7029	35.0237
140240	1.4344	1.0515	28.0986	32.9491	34.4714	31.9066
140242	1.6355	1.0503	36.8032	40.7474	41.8148	39.8954
140250	1.2990	1.0515	32.9414	33.7382	35.9552	34.1583
140251	1.4663	1.0515	29.5941	31.5378	33.9137	31.6519
140252	1.5144	1.0515	36.1531	37.6031	38.6010	37.4880
140258	1.7431	1.0515	34.5696	34.9198	36.5007	35.3489
140275	1.4119	0.8658	26.7394	26.7114	28.4089	27.3093
140276	2.0654	1.0515	32.7073	33.1620	35.5860	33.8463
140280	1.4890	0.8658	26.9835	28.0388	28.9833	28.0224
140281	1.7722	1.0515	37.5700	38.6663	40.3035	38.8921
140286	1.2278	1.0503	32.2246	38.2039	37.1421	35.9395
140288	1.6334	1.0503	32.5472	34.1167	37.2937	34.6391
140289	1.3772	0.9060	26.0872	26.7573	27.9748	26.9787
140290	1.5455	1.0515	35.9679	34.5766	36.0910	35.5293
140291	1.6451	1.0736	32.7884	34.2987	37.6820	34.9828
140292	1.3397	1.0503	32.4496	32.9675	34.8169	33.4335
140294	1.2039	0.8380	26.9789	27.4105	29.1291	27.8159
140300	1.0783	1.0515	37.4508	35.5837	50.8399	41.0132
140301	0.9779	1.0515	35.9742	*	25.6069	29.8693
140303	2.2113	1.0515	33.0359	31.4718	27.9269	30.4360

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140304	1.4263	1.0503	*	*	*	*
150001	1.2764	0.9555	32.9804	32.5348	32.6297	32.7148
150002	1.6234	1.0370	28.1076	28.3271	29.6905	28.6820
150003	1.7222	0.9253	29.3660	30.1317	33.7073	30.8984
150004	1.5661	1.0370	31.7867	34.4889	35.7071	34.0029
150005	1.3511	0.9555	31.6090	32.6541	33.1179	32.4681
150006	1.4802	0.9488	28.3403	29.7289	30.6306	29.5973
150007	1.5994	0.9010	31.0384	32.4836	32.2298	31.9370
150008	1.4456	1.0370	29.1492	30.9426	33.9870	31.5695
150009	1.5710	0.8850	26.1517	25.9625	26.7891	26.3075
150010	1.6352	0.9010	28.2616	32.8116	30.3873	30.4161
150011	1.3841	0.9555	27.7870	27.8089	29.9431	28.4970
150012	1.5535	0.9889	31.6762	32.0116	33.6506	32.4574
150015	1.4932	0.9069	30.2516	32.6995	36.4154	32.8813
150017	1.7290	0.9245	27.1262	27.4538	30.5938	28.4044
150018	1.6443	0.9488	30.0928	30.9511	32.3280	31.1271
150021	1.7703	0.9245	31.1158	33.1505	34.1233	32.7891
150022	1.0676	0.8557	26.9525	29.7752	29.6975	28.8110
150023	1.5976	0.9555	30.3667	30.8457	32.8854	31.3908
150024	1.6680	0.9555	30.6154	32.1844	32.4374	31.8086
150026	1.2688	0.9488	31.9397	33.1225	34.1049	33.0885
150029	***	*	31.0692	32.1154	34.7470	32.5698
150030	1.1399	0.9555	31.1986	34.5137	33.5357	33.0658
150033	1.4780	0.9555	32.9469	31.7314	32.8768	32.5228
150034	1.5129	1.0370	30.0048	30.9961	32.0665	31.0341
150035	1.4857	0.9069	29.2039	27.9432	28.4279	28.5206
150037	1.4116	0.9555	30.4640	32.2960	34.2666	32.3692
150038	1.2551	0.9555	31.9552	32.2545	32.5543	32.2583
150042	1.3233	0.8757	25.2456	25.2218	26.7161	25.7175
150044	1.5944	0.8850	25.9284	26.6389	28.1622	26.9147
150045	0.9713	0.8399	29.4323	30.0052	30.9207	30.1025
150046	1.5593	0.9254	27.6228	29.7184	30.9654	29.3854
150047	1.6689	0.9245	27.1847	27.9365	31.6507	28.8997
150048	1.5145	0.9637	29.5588	30.5008	32.3958	30.8298
150051	1.6271	0.9555	30.3764	31.2746	32.2657	31.3278
150056	2.0215	0.9555	30.5777	30.8461	32.4031	31.2946
150057	1.8617	0.9555	29.2358	30.4490	32.1298	30.5843

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
150058	1.6714	0.9889	31.7558	32.4036	35.0250	33.0649
150059	1.4935	0.9555	36.2570	30.4189	32.7391	32.9236
150061	1.1637	0.8399	23.2427	24.7808	25.5354	24.5382
150064	1.1633	0.9555	28.9430	29.7898	31.2189	29.8692
150065	1.2812	0.9555	30.7970	31.7556	30.5764	31.0263
150069	1.1856	0.9637	27.0740	28.6514	29.6637	28.4852
150072	1.1231	0.8504	23.0619	24.6596	25.9259	24.5284
150074	1.4197	0.9555	29.4135	31.6043	32.2693	31.1351
150075	1.1147	0.9245	26.5987	27.1412	29.3253	27.5816
150076	1.3188	0.9488	30.2972	29.4643	30.9772	30.2388
150082	1.5964	0.8399	28.1302	28.0003	28.9121	28.3718
150084	1.8928	0.9555	35.0288	35.4818	35.6641	35.4130
150086	1.1942	0.9637	27.2580	28.8279	29.7408	28.6114
150088	1.3132	0.9555	30.2396	31.9171	33.4869	31.8591
150089	1.7163	0.8736	26.7290	28.0389	28.6143	27.7655
150090	1.4939	1.0370	30.9274	33.6812	32.6472	32.3780
150091	1.1504	0.9245	33.0421	32.9027	32.9069	32.9497
150097	1.2299	0.9555	29.4797	29.9967	31.3599	30.2962
150100	1.6908	0.8399	27.6339	30.0246	30.5792	29.4364
150101	1.0091	0.9245	31.6031	32.5860	33.5799	32.5996
150102	1.0478	0.9069	25.4717	30.4952	30.6858	28.7323
150104	1.2531	0.9555	30.8984	31.2245	32.6367	31.6520
150109	1.6020	0.9253	29.0076	31.0757	31.1542	30.3473
150112	1.5048	0.9555	31.7966	32.0659	33.0833	32.3322
150113	1.2748	0.9555	26.9098	29.0485	31.1284	29.0331
150115	1.3849	0.8399	22.3571	25.0221	22.3911	23.2176
150125	1.5510	1.0370	30.7113	31.6959	31.3249	31.2479
150126	1.3388	1.0370	32.6488	34.5086	34.8705	34.0137
150128	1.4381	0.9555	31.1071	30.7549	33.5421	31.8223
150129	1.4581	0.9555	32.9629	36.4709	35.4468	35.0559
150133	1.1372	0.9488	23.0662	25.1415	27.9662	25.3965
150134	***	*	27.3983	30.4440	*	28.8978
150146	1.1222	0.9457	31.8757	32.9491	33.5246	32.8186
150147	***	*	28.9269	28.9204	25.8261	28.0014
150149	0.9508	0.8399	25.3350	26.4595	28.5387	26.8755
150150	1.3103	0.9245	26.5984	26.5020	30.8735	28.0119
150153	2.2954	0.9555	37.3948	38.6948	40.7215	38.9628

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
150154	2.2826	0.9555	30.5775	32.3383	33.4212	32.1347
150157	1.7623	0.9555	32.9167	35.4134	36.4550	34.9919
150158	1.3123	0.9555	30.4355	31.5245	33.9116	32.0793
150159	***	*	27.5595	*	*	27.5595
150160	2.0703	0.9555	27.6375	31.2957	35.6878	31.9424
150161	1.6991	0.9555	*	32.3409	32.7880	32.5716
150162	1.8807	0.9555	*	32.2317	34.3034	33.2490
150163	1.0317	0.8850	*	26.0437	25.0146	25.4847
150164	1.2919	0.9287	*	*	34.3607	34.3607
150165	1.4820	1.0370	*	*	29.3019	29.3019
150166	0.9623	1.0370	*	*	22.9271	22.9271
150167	2.3686	0.9245	*	*	*	*
150168	2.1247	0.9245	*	*	*	*
150169	1.6356	0.9555	*	*	*	*
150170	1.3876	1.0370	*	*	*	*
150172	1.6329	0.8850	*	*	*	*
150173	1.6384	0.9253	*	*	*	*
150174	0.9714	0.9069	*	*	*	*
150175	2.3255	0.8399	*	*	*	*
150176	2.7334	0.8850	*	*	*	*
160001	1.3311	0.9525	25.8686	27.4207	28.7099	27.3326
160005	1.2769	0.8533	24.8597	25.6204	27.4917	26.1096
160008	0.9769	0.8533	24.1282	24.3704	24.4497	24.3155
160013	1.2219	0.8712	25.5162	26.6913	28.1891	26.7376
160016	1.5478	0.9273	26.6537	27.9879	28.8021	27.8144
160024	1.5796	0.9525	32.4253	32.7762	34.4365	33.1992
160028	1.4350	0.9550	29.8343	32.4639	33.7785	32.0904
160029	1.5442	0.9550	32.2035	33.7679	34.1917	33.3869
160030	1.3905	1.0044	30.4779	32.0333	35.0846	32.5833
160032	0.9942	0.8768	28.5645	29.0326	31.8085	29.8300
160033	1.6046	0.8654	27.4810	27.6537	29.9665	28.3732
160040	1.4565	0.8533	28.2982	27.9810	28.9805	28.4165
160045	1.7963	0.8799	28.1681	30.0063	30.1557	29.4747
160047	1.2816	0.9550	29.4286	31.2897	32.5410	31.0812
160057	1.5524	0.9422	27.7969	28.3640	29.9080	28.7095
160058	2.0933	0.9550	29.8975	31.2742	33.2320	31.5155
160064	1.4740	0.9142	33.6082	32.7787	33.3370	33.2334

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
160067	1.4190	0.8533	26.7679	27.2055	27.9863	27.3213
160069	1.5388	0.8562	28.4081	29.0981	30.1739	29.2235
160079	1.5326	0.8799	28.5034	29.8338	31.5836	30.0015
160080	1.2455	0.8654	27.8745	27.4136	29.4683	28.2508
160082	1.8108	0.9525	31.7508	34.0609	34.3141	33.3856
160083	1.7250	0.9525	29.9489	31.0514	33.2497	31.4494
160089	1.3913	0.8533	23.9194	25.0810	26.2942	25.0591
160101	1.1089	0.9525	26.8515	27.1889	27.7523	27.2723
160104	1.6136	0.8654	27.0538	27.8486	29.6187	28.2439
160110	1.5439	0.8533	29.9094	30.8876	32.2713	31.0216
160112	1.2738	0.8533	26.1721	26.7136	28.5427	27.1637
160117	1.4386	0.8562	24.3326	28.8434	29.5419	27.4138
160122	1.1901	0.8533	25.3192	26.6212	27.6209	26.5321
160124	1.0341	0.8533	25.5048	27.2937	27.7842	26.8757
160146	1.5275	0.8964	25.1834	27.1213	27.6992	26.6860
160147	1.1959	0.9273	33.6394	37.2058	33.7922	34.8361
160153	1.7431	0.8964	30.4356	32.1357	33.9188	32.1398
160155	***	*	*	30.2301	*	30.2301
160156	1.6040	0.8799	*	*	*	*
170001	1.1336	0.8027	24.5942	26.2914	27.4924	26.1347
170006	1.3107	0.8448	28.3527	30.5591	29.7039	29.5405
170009	1.1982	0.9558	32.2847	29.3342	35.8139	32.4214
170010	1.2280	0.8027	28.1802	28.6734	28.0225	28.2857
170012	1.6238	0.8027	28.7878	30.0388	31.3285	30.0679
170013	1.8476	0.8886	28.3051	29.6511	29.3136	29.1030
170014	1.0892	0.9558	25.8165	27.2909	28.6642	27.2564
170016	1.7045	0.9138	28.6817	31.9998	32.2154	30.9367
170017	1.1853	0.8860	29.1463	29.5447	30.5545	29.7618
170020	1.5234	0.8756	25.0561	26.1258	27.5267	26.2659
170023	1.4396	0.8027	24.8827	24.9932	23.5945	24.4631
170027	1.4459	0.8027	24.1133	24.6748	28.0618	25.5280
170033	1.2736	0.8756	25.0404	26.9830	28.5416	26.8290
170039	1.0418	0.8860	23.5975	24.1339	25.9946	24.6007
170040	1.9930	0.9558	30.0828	33.3813	34.7542	32.6359
170049	1.5816	0.9558	31.8595	34.8212	36.0453	34.2790
170058	1.0032	0.9558	28.1330	28.6239	28.3939	28.3847
170068	1.1495	0.8438	23.8509	25.6803	26.5991	25.3770

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
170074	1.1194	0.8027	24.8871	26.7280	27.0989	26.2418
170075	0.8374	0.8027	21.1965	20.9091	23.3361	21.8104
170086	1.5306	0.9138	28.5260	30.0102	31.6797	30.1229
170094	0.9016	0.8027	17.1719	26.4808	26.5182	22.5983
170103	1.4110	0.8860	25.5671	26.2628	27.2927	26.3968
170104	1.5054	0.9558	29.7793	31.7058	33.9851	31.8232
170105	1.0539	0.8027	23.4332	24.4249	25.3842	24.4229
170109	1.2001	0.9558	29.0197	33.0257	35.5902	32.6026
170110	0.9742	0.8027	24.7927	26.7359	27.8054	26.4654
170120	1.5992	0.8027	23.5287	24.9819	25.5442	24.7148
170122	1.7938	0.8860	29.6337	31.0839	31.6953	30.8189
170123	1.8214	0.8860	28.7627	29.1591	30.2106	29.3841
170133	1.0783	0.9558	25.7129	27.6138	29.6857	27.6809
170137	1.5460	0.8027	26.8029	28.6556	29.7218	28.4175
170142	1.4422	0.8948	25.5567	26.4060	27.8156	26.6242
170145	1.2223	0.8027	25.3745	26.5981	26.7895	26.2826
170146	1.6495	0.9558	31.7023	31.6451	33.8549	32.3707
170147	***	*	21.4581	*	*	21.4581
170150	1.1460	0.8193	22.0265	22.2379	22.4168	22.2250
170166	0.9627	0.8027	24.1079	24.4570	25.1569	24.5747
170175	1.2714	0.8756	31.7600	30.1456	32.3747	31.4397
170176	1.6710	0.9558	30.1135	31.4048	32.9892	31.5099
170182	1.4837	0.9558	30.3805	32.3903	32.5488	31.7971
170183	2.0144	0.8860	27.7207	27.5559	27.2280	27.4870
170185	1.3885	0.9558	29.3226	31.0813	31.8944	30.8239
170186	2.5662	0.8860	30.7673	36.3546	37.5555	34.8719
170187	1.8179	0.8027	24.6419	26.2236	27.0072	25.9990
170188	2.0192	0.9558	33.7247	34.0134	35.3969	34.4593
170190	1.0539	0.8027	27.3041	28.7392	29.4546	28.5196
170191	1.6762	0.8027	26.0305	26.2347	26.3239	26.2056
170192	1.8218	0.8860	30.9230	31.7531	31.2301	31.3156
170193	***	*	24.4131	21.9349	*	23.1732
170194	1.3210	0.9558	28.2004	29.8055	35.7190	31.0251
170195	2.6049	0.9558	29.1787	31.0187	31.1434	30.5894
170196	2.4657	0.8860	29.9671	29.9241	30.4796	30.1295
170197	2.3696	0.8860	*	*	33.5871	33.5871
170198	1.9628	0.8027	*	*	21.2698	21.2698

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
180001	1.3332	0.9634	29.9674	29.7832	30.9838	30.2388
180002	1.0159	0.8060	27.3344	28.4044	31.5452	29.0298
180004	1.1704	0.7992	22.0626	25.7454	24.9532	24.2670
180005	1.1872	0.7992	27.4317	27.9687	27.9438	27.7826
180007	***	*	26.9440	29.3465	27.5457	27.8795
180009	1.7787	0.8919	28.7048	28.9804	29.4309	29.0610
180010	2.0260	0.8798	28.2168	29.8818	30.7775	29.6381
180011	1.7841	0.8798	25.0372	26.6072	27.6650	26.5198
180012	1.5168	0.8848	27.2851	27.8386	29.2425	28.1376
180013	1.5078	0.9320	26.8108	28.6307	30.5698	28.7209
180016	1.3865	0.7992	26.9539	28.2975	29.3722	28.1740
180017	1.3206	0.8347	25.4174	26.0927	26.1053	25.8753
180018	1.4264	0.7992	24.9874	25.0082	26.1033	25.3849
180019	1.1841	0.7992	27.6801	27.5969	28.3775	27.8968
180020	1.0587	0.8060	26.8865	29.8100	32.2271	29.5397
180021	0.9701	0.7992	22.3768	24.2127	25.2066	23.9245
180024	1.2076	0.8389	26.9553	27.8181	29.6250	28.1394
180025	1.4648	0.8848	28.4172	30.2576	30.4293	29.7381
180027	1.1926	0.7992	23.3881	24.0032	25.5862	24.3439
180029	1.3851	0.8798	26.3907	29.1400	33.4416	29.5244
180035	1.5342	0.9634	34.0370	36.6577	38.6645	36.4402
180036	1.4322	0.8919	30.2643	31.9987	31.3634	31.1868
180037	***	*	33.1897	28.5734	*	30.8765
180038	1.6881	0.7992	28.2430	28.5219	29.7930	28.8753
180040	1.8998	0.8848	30.2471	28.9562	29.2132	29.3762
180043	1.0208	0.7992	24.0582	25.0444	25.3256	24.8642
180044	1.7655	0.8767	25.7990	27.7934	29.8308	27.8637
180045	1.4112	0.9634	29.9366	29.9395	30.5356	30.1379
180046	1.1858	0.8798	28.5568	30.0536	32.2894	30.3563
180048	1.3799	0.8848	24.6800	25.3490	26.8313	25.6487
180049	1.5640	0.8480	23.5756	25.8921	26.3445	25.2345
180050	1.0789	0.7992	26.7726	29.9911	31.6423	29.3799
180051	1.3473	0.7992	25.2369	26.2560	27.0283	26.1992
180053	0.9345	0.7992	23.0302	24.6694	23.9194	23.8815
180056	1.1784	0.8393	26.3973	26.6223	27.8825	26.9638
180064	1.3127	0.8306	21.9517	22.5090	22.7958	22.4385
180066	1.0981	0.8431	24.9542	27.2184	27.9417	26.6868

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
180067	2.0349	0.8798	29.6053	28.9896	30.0550	29.5697
180069	1.0562	0.8767	27.6785	29.9406	32.9994	30.0147
180070	1.3985	0.8232	21.3707	22.8450	24.2407	22.8589
180078	1.1477	0.8767	29.2136	27.4672	28.5438	28.3969
180079	1.1129	0.8251	24.9911	27.2710	26.6427	26.2944
180080	1.2983	0.7992	25.3013	27.2402	28.8798	27.1688
180087	1.3935	0.7992	22.1063	23.2617	24.6628	23.3436
180088	1.8784	0.8848	30.7954	31.8151	32.8838	31.8430
180092	1.2199	0.8798	25.2900	27.0330	26.1035	26.1598
180093	1.6163	0.7992	22.3330	23.5805	24.2302	23.4008
180095	0.9817	0.7992	21.2162	23.9869	25.2742	23.4675
180101	1.3075	0.8798	28.8772	29.6176	31.3685	30.0013
180102	1.5096	0.8361	27.3901	28.3445	26.8886	27.5244
180103	1.8987	0.8798	29.7648	31.7171	33.5024	31.6641
180104	1.5028	0.8361	27.1292	28.7669	29.7545	28.5731
180105	0.9798	0.7992	24.3663	22.9902	23.8783	23.7503
180106	0.8418	0.7992	21.2271	20.1899	21.6369	21.0328
180115	0.9093	0.7992	22.7095	24.9627	24.7222	24.1589
180116	1.3811	0.8361	26.8850	26.9052	28.8350	27.5313
180117	0.8909	0.7992	24.9571	25.9593	32.4322	27.4620
180124	1.4443	0.9320	27.1359	28.2511	30.0346	28.4149
180127	1.3104	0.9634	28.3635	29.8610	30.7333	29.6661
180128	0.9465	0.7992	23.7778	23.9098	25.5746	24.4176
180130	1.6650	0.8848	29.6751	31.2746	32.7395	31.2576
180132	1.3644	0.8798	29.0563	29.5884	29.0754	29.2355
180138	1.2014	0.8848	29.2603	30.7144	32.5413	30.8691
180139	1.0292	0.7992	26.2450	28.3450	28.6303	27.6831
180141	1.9520	0.8848	28.7329	29.5347	30.4173	29.5803
180143	1.7482	0.8798	28.0780	29.0323	30.9817	29.3864
180149	1.0602	0.7992	16.4918	16.3670	21.0293	17.8136
180150	***	*	*	27.9388	*	27.9388
180151	***	*	*	*	30.5548	30.5548
190001	1.2286	0.7946	22.5331	25.3862	29.4366	25.9390
190002	1.6804	0.8473	25.9387	27.1770	27.9755	27.0325
190003	1.4192	0.8473	28.0899	30.5381	32.3943	30.3019
190004	1.5130	0.7992	24.6563	27.0776	27.9541	26.6299
190005	1.6165	0.9005	28.3308	32.9927	37.7220	33.1294

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190006	1.3802	0.8473	25.4826	28.9179	29.0341	27.9150
190007	1.1745	0.7946	24.0538	24.6117	25.6561	24.7757
190008	1.7700	0.7992	27.2683	28.1194	28.2325	27.8874
190009	1.0153	0.8164	25.0269	24.8263	26.5888	25.4978
190011	1.0472	0.8122	21.9174	24.2068	26.6802	24.1700
190013	1.5009	0.8202	22.8380	25.2468	25.4352	24.5312
190014	1.1793	0.7946	24.5410	25.6064	40.7501	28.3699
190015	1.4420	0.9005	26.9591	29.5241	30.0800	28.8947
190017	1.4652	0.8473	25.5477	26.9640	25.4720	25.9802
190019	1.7524	0.8164	27.6057	28.6311	28.7429	28.3536
190020	1.3278	0.8726	24.2361	25.9262	28.0273	26.1642
190025	1.3326	0.7946	26.5949	26.6296	28.3544	27.1661
190026	1.7583	0.8164	25.3752	27.0875	28.8897	27.0946
190027	1.6967	0.8202	31.5047	29.4789	30.4014	30.3905
190034	1.1283	0.8135	22.9920	24.3969	26.3116	24.6129
190036	1.7818	0.9005	29.1818	27.7969	28.4731	28.4470
190037	0.7254	0.8202	28.0463	19.5982	18.7972	23.3675
190039	1.6259	0.9005	24.6848	29.0738	29.9665	27.9939
190040	1.4743	0.9005	28.2444	29.0914	29.9696	29.1339
190041	1.5169	0.8651	28.7702	29.3296	30.0940	29.3847
190044	1.2801	0.8207	22.2462	23.1701	24.3770	23.2873
190045	1.5746	0.9005	27.5873	29.2569	30.1234	29.0388
190046	1.6328	0.9005	25.1890	30.9760	30.5410	29.0312
190050	1.2653	0.7990	22.7962	23.6921	25.5258	24.0045
190053	1.2074	0.8047	20.6289	22.1404	23.5988	22.1805
190054	1.3179	0.8031	23.5137	26.5586	26.1148	25.4390
190060	1.4983	0.8202	19.8911	25.1496	27.7720	23.8818
190064	1.7058	0.8726	26.9960	28.6273	31.9836	29.2661
190065	1.7366	0.8726	22.9861	24.3651	27.9398	25.1110
190078	1.1497	0.8133	25.6943	26.0185	29.3271	27.0437
190079	1.1235	0.9005	25.3344	28.0268	29.1127	27.5269
190081	0.8388	0.7946	20.4111	21.2224	19.7228	20.4547
190086	1.3020	0.8122	22.2852	24.2040	26.9719	24.3187
190088	1.0754	0.8333	24.7450	29.5999	28.2045	27.5180
190090	0.9838	0.7946	25.8610	25.0681	27.3204	26.0691
190098	1.7167	0.8651	27.5058	27.8846	30.6530	28.7025
190099	1.0253	0.8135	25.7488	25.7136	28.4919	26.6705

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190102	1.5099	0.8473	28.3090	28.6165	29.3771	28.7633
190106	1.1005	0.8164	24.2759	25.5188	28.9361	26.2131
190111	1.7590	0.8651	27.3192	28.8406	30.5678	28.9640
190114	1.0703	0.7946	20.3651	21.1463	21.6231	21.0606
190115	***	*	26.0285	25.7014	26.8130	26.0523
190116	1.0753	0.8031	24.2154	24.4439	24.8437	24.4763
190118	1.0876	0.8651	22.6572	22.3386	23.2836	22.7652
190122	1.0958	0.8726	22.8681	24.5686	31.3913	26.4871
190124	***	*	28.6713	*	*	28.6713
190125	1.6466	0.8122	26.6269	26.9761	28.3593	27.4096
190128	1.0737	0.8726	31.1819	32.2095	33.7971	32.4200
190131	1.0333	0.8726	28.5946	29.9837	*	29.2828
190133	0.9268	0.8048	23.9550	27.2643	30.2477	27.1223
190135	1.4976	0.9005	35.0547	43.3956	30.1783	34.5478
190140	0.9443	0.7981	23.6713	23.2346	24.0204	23.6404
190144	1.3143	0.8651	24.8866	25.8501	28.3036	26.4021
190145	0.9783	0.8036	21.3988	22.1298	23.2156	22.2666
190146	1.5988	0.9005	28.5984	29.8336	31.9250	30.1773
190151	0.8796	0.7946	20.6970	23.0032	23.1695	22.2541
190152	***	*	34.6508	34.6962	*	34.6751
190158	***	*	21.5594	*	*	21.5594
190160	1.5857	0.8122	25.8646	26.4460	30.4379	27.3739
190161	1.1145	0.8202	23.8073	24.8249	29.2908	26.0454
190164	1.1621	0.8022	27.7265	28.2630	29.1501	28.3895
190167	1.1858	0.8473	27.1981	29.3971	31.7116	29.4476
190175	1.4156	0.9005	30.5948	31.4039	32.4181	31.4544
190176	1.8915	0.9005	28.2192	32.2906	33.3670	31.0851
190177	1.8394	0.9005	29.7252	30.9158	33.1157	31.2414
190182	***	*	30.7058	*	*	30.7058
190183	1.3719	0.7992	23.3462	25.0395	27.3509	25.2419
190184	0.9910	0.7993	22.6144	22.5006	23.5652	22.8901
190185	***	*	36.7317	*	*	36.7317
190190	0.9500	0.8122	27.5051	27.5875	28.9875	28.1199
190191	1.2692	0.8133	26.9656	28.1116	32.0257	28.8862
190196	0.8810	0.8473	27.7824	28.4697	30.6579	29.0035
190197	***	*	28.7044	29.4072	*	29.0218
190199	1.0401	0.8726	36.7128	29.8286	28.2996	31.3500

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190201	1.1431	0.8202	26.8550	27.8244	29.9264	28.1877
190202	1.6103	0.8726	27.6463	27.8790	27.6445	27.7278
190204	1.5181	0.9005	32.9140	31.9034	33.9644	32.9173
190205	1.7463	0.8473	30.1687	31.6103	32.4248	31.3896
190206	***	*	32.0180	30.4228	*	31.2019
190208	0.8027	0.7946	24.9405	27.5238	30.0154	27.5723
190218	0.8614	0.8651	26.5251	26.9305	28.1252	27.1844
190236	1.4843	0.8651	26.9059	28.6472	30.3119	28.6612
190241	1.3729	0.7992	26.5320	27.5130	28.2954	27.5238
190242	1.3789	0.8726	26.9729	28.7307	28.2808	28.0344
190245	1.4118	0.8122	26.4166	26.6403	28.0180	26.9888
190246	2.1718	0.7993	31.7158	31.5003	31.9438	31.7321
190249	***	*	27.0975	28.3211	25.9997	26.9704
190250	2.2150	0.9005	32.8381	35.2699	34.8604	34.3606
190251	1.3719	0.8726	25.1594	27.3657	22.3853	24.6260
190253	***	*	22.2227	*	*	22.2227
190255	0.8263	0.8473	23.8035	27.8066	29.2058	26.9371
190256	1.0879	0.9005	25.9365	28.7148	28.7915	27.9122
190257	1.7222	0.8122	22.7512	24.2936	25.5176	24.1258
190258	1.8369	0.8651	25.1993	27.7948	22.8748	24.8290
190259	2.1986	0.8473	27.5518	28.9188	32.6301	29.7424
190260	***	*	33.6227	*	*	33.6227
190261	1.5307	0.8122	25.4757	28.7987	29.7560	28.0746
190263	2.3305	0.8473	29.7063	36.3082	35.0861	33.5957
190265	***	*	30.9260	*	*	30.9260
190266	2.9075	0.8726	24.3809	32.3423	32.8535	29.9624
190267	1.4667	0.9005	24.2794	27.6254	30.2475	27.6505
190268	1.5022	0.8473	29.1425	25.8619	27.3050	27.2594
190270	1.8564	0.9005	*	28.5382	29.0574	28.8214
190272	1.3915	0.8473	28.4558	28.4184	23.0702	27.0083
190273	1.8338	0.8726	*	22.7627	21.7837	22.2231
190274	1.8427	0.9005	*	*	28.1128	28.1128
190275	***	*	*	*	29.8209	29.8209
190278	2.3634	0.8651	*	*	23.8972	23.8972
190297	1.1631	0.7946	*	*	*	*
200001	1.3741	0.9695	28.1145	28.9839	29.1670	28.7667
200002	1.2267	0.9509	33.2695	30.4965	27.7502	29.9690

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
200008	1.4018	0.9930	29.3538	32.3955	34.1427	32.0121
200009	1.9252	0.9930	35.0743	36.9995	36.6216	36.2321
200018	1.3541	0.8589	24.6790	25.4228	25.7060	25.2725
200019	1.4200	0.9930	28.3413	30.1233	30.4156	29.6126
200020	1.2880	1.0218	34.5762	36.9185	40.2167	37.3309
200021	1.2139	0.9930	28.7614	31.8322	32.8539	31.2416
200024	1.6897	0.9509	31.0799	31.6913	31.9731	31.6024
200025	1.0822	0.9930	29.3607	30.2866	27.5904	29.0492
200031	1.2922	0.8589	23.7553	25.5973	25.9030	25.1172
200032	1.0966	0.8920	27.2276	27.8426	29.5270	28.2308
200033	1.8148	0.9695	33.6293	34.8017	34.8344	34.4346
200034	1.5798	0.9509	28.0417	28.5612	29.9180	28.9063
200037	1.1561	0.8589	26.7815	27.9167	29.6936	28.2024
200039	1.3319	0.9509	28.8043	29.9958	31.1083	30.0137
200040	1.0262	0.9930	25.5519	29.6104	29.7535	28.2949
200041	1.2990	0.8589	27.5067	28.7604	34.7992	30.1914
200050	1.1681	0.9695	30.1473	32.0363	34.1295	32.1599
200052	1.0602	0.8589	25.6238	24.4545	27.8885	25.8956
200063	1.1945	0.8589	28.2203	29.6832	30.0507	29.3664
210001	1.5177	0.9692	31.2355	30.9218	34.1438	32.0935
210002	2.0643	1.0198	36.0252	36.8782	37.3977	36.7890
210003	1.5893	1.0561	28.2566	34.4117	33.3073	31.8002
210004	1.4458	1.0573	33.9037	32.4548	34.4088	33.6063
210005	1.4195	1.0573	32.4081	32.2224	36.0013	33.5795
210006	1.1291	1.0198	27.9859	31.8510	33.3367	31.1101
210007	1.7980	1.0198	31.4125	35.3019	40.3645	35.4047
210008	1.4858	1.0198	31.8535	33.0343	33.6017	32.8716
210009	1.8265	1.0198	31.8273	34.4385	37.6659	34.7016
210011	1.4747	1.0198	30.7547	29.7694	28.5986	29.6638
210012	1.7244	1.0198	32.5327	33.8099	34.9535	33.8058
210013	1.3276	1.0198	32.1180	35.6347	35.7358	34.5777
210015	1.3298	1.0198	31.6903	34.7961	35.0662	33.9077
210016	1.8075	1.0573	35.3253	37.1478	38.1774	36.9059
210017	1.1984	0.9305	26.6208	27.9652	27.6553	27.4194
210018	1.2329	1.0573	31.5460	33.7284	36.4156	33.9785
210019	1.7439	0.9305	30.5485	30.8121	31.7957	31.0539
210022	1.5465	1.0573	36.1833	35.8394	37.6708	36.5871

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
210023	1.5697	1.0277	34.1664	35.8243	37.3156	35.8033
210024	1.7983	1.0198	34.5548	36.7920	36.9018	36.1089
210025	1.3682	0.9305	23.5175	28.3956	29.8053	27.1446
210027	1.4746	0.9305	25.2143	25.6339	27.5980	26.1526
210028	0.9952	0.9559	28.5214	31.7636	34.3131	31.6983
210029	1.3475	1.0198	32.9100	33.9139	34.5075	33.8223
210030	1.1460	0.9305	29.1790	33.8729	34.4330	32.5402
210032	1.2840	1.0802	29.2785	31.6516	32.2034	31.0732
210033	1.2494	1.0198	28.4350	33.0982	34.9230	32.1677
210034	1.3548	1.0198	33.0407	35.1533	36.2172	34.8437
210035	1.3316	1.0561	30.6692	28.7165	34.0007	31.1344
210037	1.2971	0.9305	28.8708	31.0096	32.7661	30.9387
210038	1.3568	1.0198	31.1563	32.7411	36.1404	33.3841
210039	1.1580	1.0561	35.1172	33.7557	36.9817	35.3260
210040	1.2899	1.0198	31.0882	30.5834	32.5361	31.4068
210043	1.3938	1.0277	29.2762	31.9196	36.7035	32.5832
210044	1.3943	1.0198	31.5463	31.9067	33.9671	32.5153
210045	0.9460	0.9305	19.6112	23.8454	23.8643	22.3580
210048	1.4049	1.0198	29.2464	30.6650	32.7111	30.9342
210049	1.3689	1.0198	28.5970	31.5740	32.8713	31.1060
210051	1.3877	1.0561	30.7954	33.0355	33.8704	32.6204
210054	1.3042	1.0561	28.6905	32.3079	30.9544	30.6912
210055	1.3146	1.0561	30.2010	36.7615	34.9377	33.7047
210056	1.4309	1.0198	33.2271	35.5593	36.1736	34.9799
210057	1.4422	1.0573	33.7287	34.3643	36.7381	34.9642
210058	1.3962	1.0198	32.0669	32.9569	31.3100	32.0828
210060	1.1535	1.0561	32.5141	34.1974	35.0184	33.9386
210061	1.3663	0.9305	26.6842	28.6561	29.3158	28.2516
220001	1.3129	1.1613	32.0843	34.3993	36.2517	34.3061
220002	1.3674	1.1613	35.9765	37.9204	41.2350	38.3812
220008	1.3871	1.1613	35.8680	37.3794	38.4715	37.2430
220010	1.2534	1.1613	33.7392	36.1759	37.2035	35.7194
220011	1.1936	1.1613	39.1234	41.0183	43.4600	41.2510
220012	1.4849	1.2825	41.7080	43.0551	45.5643	43.4397
220015	1.2957	1.0361	35.2373	36.6427	36.3548	36.1085
220016	1.1444	1.0361	33.1424	34.9714	36.4237	34.8489
220017	1.3175	1.2342	34.6575	38.0626	37.7006	36.8223

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
220019	1.1234	1.1613	26.3018	28.0084	29.0921	27.8076
220020	1.2029	1.1613	32.1528	33.6332	35.4990	33.7696
220024	1.3423	1.0361	33.0415	33.8692	34.5389	33.8318
220025	0.9616	1.1613	27.6973	26.6082	29.5458	27.9060
220029	1.2117	1.1613	32.6792	34.8311	36.1946	34.5999
220030	1.0618	1.0361	29.3714	28.8797	29.5814	29.2776
220031	1.5941	1.2342	39.4214	43.7983	46.0432	43.1210
220033	1.2423	1.1613	34.7005	36.1938	40.1729	37.0696
220035	1.4532	1.1613	36.1799	37.2879	39.7370	37.7407
220036	1.5744	1.2342	37.7301	37.0998	37.8321	37.5495
220046	1.5340	1.0483	33.8604	36.3356	37.2026	35.8565
220049	1.2222	1.1613	35.1134	35.7550	37.2433	36.0618
220050	1.1147	1.0361	30.3176	32.4636	33.3155	32.0704
220051	1.4962	0.9671	32.8693	34.7850	33.7650	33.7771
220052	1.2183	1.2342	34.9151	34.9505	36.2809	35.4000
220058	0.9958	1.1613	30.0344	31.9532	34.4760	32.1059
220060	1.1949	1.2342	36.8668	39.1180	41.3006	39.2150
220062	0.7353	1.1613	27.4755	27.3983	28.6128	27.8434
220063	1.3010	1.1613	32.2442	34.6004	35.5788	34.2281
220065	1.2968	1.0361	32.3814	33.6328	34.7541	33.5673
220066	1.4186	1.0361	*	32.6289	35.0834	33.8457
220067	1.2573	1.2342	33.9836	35.7611	37.4704	35.7586
220070	1.1469	1.1613	35.6271	37.4036	39.9838	37.7577
220071	1.8988	1.2342	40.0313	44.2752	46.1244	43.5120
220073	1.2200	1.1613	37.4249	38.9942	39.6789	38.7046
220074[4]	1.3861	1.1613	33.2081	34.5531	36.8098	34.8867
220B74[4]	***	*	33.2082	34.5530	36.8098	34.8283
220075	1.6785	1.2342	33.3578	33.9698	34.7027	34.0072
220077	1.7243	1.1117	34.7345	36.4382	37.4924	36.2651
220080	1.2906	1.1613	33.1640	36.8086	36.4484	35.4648
220082	1.4119	1.1613	32.2124	33.0780	34.8104	33.3699
220083	1.1280	1.2342	35.2758	37.6415	40.5366	37.8780
220084	1.3987	1.1613	34.6275	36.1148	37.5379	36.1306
220086	1.8041	1.2342	36.2385	38.7853	41.1551	38.7907
220088	2.0559	1.2342	37.0840	37.3891	39.2279	37.9115
220090	1.2951	1.1613	35.8969	36.8628	39.5926	37.5164
220095	1.1067	1.1613	31.1644	34.1504	35.3675	33.6005

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
220098	1.1646	1.1613	31.1288	32.1864	33.5413	32.2804
220100	1.3340	1.2342	35.7309	36.5606	38.7440	37.0351
220101	1.4456	1.1613	37.7292	39.3939	41.7554	39.6905
220105	1.2292	1.1613	35.8179	36.6444	39.1029	37.2192
220108	1.2101	1.2342	35.7009	37.1981	38.4718	37.1647
220110	2.0616	1.2342	43.8444	45.3683	47.3232	45.5499
220111	1.2935	1.2342	35.6223	36.8788	39.2865	37.3009
220116	1.8798	1.2342	40.0982	44.6345	47.0582	43.9023
220119	1.1259	1.2342	33.7200	36.2751	37.4673	35.8320
220126	1.2307	1.2342	35.6278	40.5321	38.0733	38.0049
220135	1.4968	1.2825	39.0296	40.3011	42.8827	40.7443
220153	***	*	20.5063	17.4773	19.0273	19.2029
220154	***	*	*	*	43.7359	43.7359
220162	1.7710	*	*	*	*	*
220163	1.6759	1.1613	39.4893	41.6485	42.2659	41.1896
220171	1.6535	1.1613	36.4567	39.7385	38.8272	38.4029
220174	1.2280	1.1613	32.9140	35.8880	34.9007	34.5714
220175	1.3204	1.1613	34.1572	36.6376	38.0801	36.2674
220176	1.5591	1.1613	31.4220	36.2759	38.1158	35.1359
220177	0.9796	0.9671	*	*	*	*
230002	1.4172	0.9849	33.9708	34.2904	35.4085	34.5484
230003	1.4546	0.9386	28.9886	28.5041	30.5808	29.4057
230004	1.7665	0.9829	33.4644	33.1555	34.1260	33.5840
230005	1.3107	0.9078	29.0634	30.5550	31.3029	30.3037
230013	1.3464	1.0134	28.6430	29.9019	31.7651	29.9529
230015	1.1276	0.8900	28.9601	29.8884	32.5133	30.4506
230017	1.7269	1.0313	36.8045	35.5276	37.9122	36.7658
230019	1.6780	1.0134	35.1440	34.8302	36.2716	35.4350
230020	1.7393	0.9849	29.9492	30.4302	31.1906	30.5265
230021	1.6302	0.9979	29.5414	30.4315	31.6153	30.5478
230022	1.1397	0.9759	25.7846	29.5713	32.6757	29.2761
230024	1.7276	0.9849	34.5278	35.1416	35.9913	35.2122
230029	1.7576	1.0134	33.1482	35.5257	33.5106	34.0740
230030	1.3448	0.9102	25.1929	27.8555	29.6479	27.5704
230031	1.5302	0.9725	30.8870	30.9321	31.8722	31.2241
230034	1.3190	0.8605	29.1098	29.8711	29.1077	29.3790
230035	1.3229	0.9315	25.7099	27.0372	27.3075	26.6792

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230036	1.4412	0.8891	31.0938	31.9872	32.2768	31.7900
230037	1.2616	0.9849	28.8547	31.4423	32.0467	30.7793
230038	1.7841	0.9386	30.1040	31.5536	32.5264	31.4308
230040	1.1548	0.9315	27.2850	27.6894	27.5684	27.5177
230041	1.6226	0.9481	30.3082	31.7229	32.9174	31.6784
230046	1.9829	1.0107	33.5304	34.3952	35.9760	34.6925
230047	1.6075	0.9776	32.0248	33.2300	33.7264	32.9936
230053	1.7703	0.9849	33.5440	34.1884	35.6490	34.5004
230054	1.8298	0.9249	28.1229	28.5274	28.7117	28.4479
230055	1.3352	0.8605	28.1881	28.2657	29.6910	28.7240
230058	1.2321	0.8605	27.9643	29.2185	29.8956	29.0455
230059	1.6857	0.9386	28.3602	30.3935	32.7833	30.4889
230060	1.2298	*	28.7760	30.7515	*	29.7837
230066	1.2837	0.9829	32.3582	32.8383	34.5386	33.2625
230069	1.2686	0.9849	31.9675	33.3136	33.1722	32.8338
230070	1.6133	0.9210	28.0366	32.2151	31.6902	30.6210
230071	1.2460	1.0134	28.8879	29.6172	29.7855	29.4320
230072	1.4884	0.9386	28.8024	29.3214	30.4713	29.5569
230075	1.5124	0.9806	32.1166	33.2981	33.0856	32.8458
230077	1.8634	1.0134	31.0123	32.2274	33.2565	32.1576
230078	1.1159	0.8605	27.0069	27.7143	28.9163	27.8714
230080	1.1863	0.8605	25.6204	25.9082	27.1896	26.2395
230081	1.3269	0.8605	27.8106	27.9649	28.8068	28.1980
230085	1.1525	1.0313	27.6474	28.1395	28.6603	28.1833
230089	1.4386	0.9849	32.2311	34.4092	*	33.3212
230092	1.4241	0.9483	30.5417	29.5262	32.3303	30.8026
230093	1.1780	0.8663	27.0572	27.7275	27.1808	27.3255
230095	1.1846	0.8891	25.9210	25.9787	26.7295	26.2107
230096	1.1720	0.9979	29.7225	30.9326	35.3084	32.0067
230097	1.6800	0.9315	31.5174	32.2990	31.8133	31.8763
230099	1.2400	0.9849	29.0975	30.7388	31.3316	30.3938
230100	1.4065	0.8605	25.6594	25.9480	27.1021	26.2240
230101	1.1279	0.8605	28.8608	29.4146	30.2722	29.5256
230104[5]	1.7305	0.9849	34.0195	34.0176	35.3943	34.4648
230B04[5]	***	*	34.0195	34.0176	35.3943	34.4605
230105	1.7055	0.9315	32.1124	33.0444	32.7701	32.6587
230106	1.1686	0.9386	30.0223	29.0344	31.2500	30.1013

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230108	1.2433	0.8605	25.7477	25.4728	26.0197	25.7525
230110	1.3362	0.8605	27.0280	29.0921	30.1801	28.7817
230117	1.8114	1.0313	33.9176	33.6962	34.2863	33.9717
230118	1.2950	0.8605	24.8638	27.1359	28.4445	26.8191
230119	***	*	33.2050	33.6503	*	33.4472
230121	1.3766	1.0144	27.7512	28.9511	30.8615	29.1524
230130	1.7250	1.0134	32.5613	33.6704	34.9198	33.7273
230132	1.6023	1.1382	38.2454	39.2894	39.7151	39.0892
230133	1.3475	0.8605	25.8537	26.1806	25.7151	25.9203
230135	1.0031	0.9849	31.5194	32.6527	*	32.0720
230141	1.6878	1.1382	36.3124	36.2647	40.7648	37.7993
230142	1.4114	0.9849	29.9911	30.2157	31.2257	30.4794
230146	1.4359	0.9849	29.0218	29.3346	30.5060	29.6420
230151	1.4202	1.0134	28.6724	28.6413	30.4839	29.2693
230156	1.7070	1.0107	34.7865	35.1696	34.0537	34.6666
230165	1.6917	0.9849	32.2855	31.9887	33.4514	32.6026
230167	1.6598	1.0269	32.8092	35.8019	36.9076	35.1687
230174	1.4021	0.9386	31.2469	31.6387	31.5781	31.4917
230176	1.4667	0.9849	29.2688	29.5281	30.9173	29.9026
230180	1.2683	0.8605	24.6007	28.1401	29.3516	27.1906
230190	***	*	33.6724	30.7924	36.7558	33.6260
230193	1.4023	0.9725	28.4641	29.1474	31.5897	29.7561
230195	1.5647	0.9776	32.5549	33.4975	33.4337	33.2184
230197	1.7706	1.1382	34.8066	36.4129	39.0787	36.8022
230204	1.4815	0.9776	30.1982	31.5389	34.3475	31.9741
230207	1.4333	1.0134	26.8231	27.2054	27.4081	27.1461
230208	1.2571	0.9315	25.2481	25.8892	27.8814	26.3666
230212	1.0316	1.0107	33.4379	34.3917	34.3170	34.0488
230216	1.5184	0.9725	28.9586	30.7478	30.8494	30.1826
230217	1.5091	0.9806	33.0839	35.4957	36.9025	35.2407
230222	1.6616	0.8891	32.4404	30.6277	29.6522	30.8343
230223	***	*	31.8146	34.2971	*	33.0613
230227	1.5877	0.9776	34.2762	35.4364	37.2215	35.5888
230230	1.4717	1.0269	31.4953	31.2614	35.4132	32.7682
230236	1.5236	0.9386	31.9100	32.1973	33.9442	32.7342
230239	1.4068	0.8605	23.5461	26.8301	25.7446	25.3678
230241	1.2282	0.9725	30.0248	28.4771	28.1985	28.8297

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230244	1.4335	0.9849	32.5586	33.0082	34.3841	33.3260
230254	1.5845	1.0134	31.6332	33.3035	35.0125	33.2978
230257	0.9982	0.9776	30.0674	32.6298	33.3636	32.2062
230259	1.4407	1.0107	27.9572	28 7672	29.1866	28.6444
230264	2.1717	0.9776	29.2202	35.0990	32.8671	32.3761
230269	1.4542	1.0134	34.2694	34.4514	35.2440	34.6832
230270	1.4328	0.9849	29.2408	29.0416	30.1197	29.4618
230273	1.5702	0.9849	32.5730	32.6874	34.8800	33.4102
230275	0.5916	0.9210	22.3740	*	22.6311	22.5224
230277	1.6115	1.0134	32.2545	33.8036	33.9308	33.3444
230279	0.6904	0.9849	26.8552	26.8567	28.8581	27.5609
230297	1.8559	0.9849	*	35.4246	38.9109	37.1670
230300	***	*	*	40.1731	*	40.1731
230301	1.2227	1.0134	*	*	29.1394	29.1394
230302	1.4906	1.0134	*	*	*	*
240001	1.5641	1.1027	37.2211	38.3979	41.1376	38.9343
240002	1.8190	1.0682	34.6368	36.8748	39.2785	37.0047
240004	1.8454	1.1027	33.4596	36.5476	38.0780	36.0985
240006	1.2478	1.0759	32.8229	29.6609	33.3951	31.7330
240010	2.0987	1.0759	35.9131	37.5473	37.9757	37.1825
240014	1.0711	1.1027	33.4492	35.0675	34.9155	34.4959
240018	1.3136	0.9951	30.5645	32.3271	33.2201	32.0521
240019	1.1884	1.0682	34.2547	36.7033	37.3681	36.1294
240020	1.1431	1.1027	34.5703	34.6135	36.6782	35.2976
240022	1.0184	0.9146	28.5905	29.9313	31.1852	29.9071
240030	1.5777	0.9146	27.6596	29.4253	30.4810	29.1808
240036	1.5881	1.1027	37.2207	39.2407	40.6853	39.1270
240038	1.5960	1.1027	34.7357	35.8365	37.8663	36.2048
240040	1.0412	1.0682	30.0255	31.3287	34.0437	31.7765
240043	1.2674	0.9146	25.7424	27.1539	28.4042	27.1230
240044	1.0396	0.9771	28.5705	29.8375	29.2879	29.2433
240047	1.5709	1.0682	35.6763	36.7122	36.2255	36.2136
240050	1.2531	1.1027	33.7964	34.6160	36.3370	34.9328
240052	1.2601	0.9146	31.0934	33.1438	33.8454	32.7273
240053	1.6040	1.1027	34.4210	35.4738	36.3414	35.4352
240056	1.3478	1.1027	35.8603	36.1085	32.7052	34.7799
240057	1.9154	1.1027	34.8374	35.4436	38.0303	36.0623

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
240059	1.1327	1.1027	32.5958	33.5784	33.2499	33.1597
240061	1.8971	1.0759	34.6031	36.2545	37.5561	36.1385
240063	1.6747	1.1027	36.9822	38.3735	38.3869	37.9467
240064	1.2584	0.9280	29.9917	34.2284	35.6462	33.1970
240066	1.6077	1.1027	39.6609	38.4941	39.9654	39.3787
240069	1.2417	1.1027	31.1673	31.6325	35.5345	32.8398
240071	1.1899	1.1027	32.5460	33.1094	35.2567	33.6586
240075	1.2925	0.9146	30.3230	31.5984	32.9126	31.6235
240076	1.1549	1.1027	33.7950	35.4135	37.1723	35.5183
240078	1.7615	1.1027	36.2276	37.3608	39.4962	37.7013
240080	2.0360	1.1027	36.5390	37.7353	39.9460	38.0844
240084	1.1431	1.0682	29.0275	30.3789	32.3263	30.5812
240088	1.2605	0.9146	30.7240	31.4165	32.7525	31.5969
240093	1.5139	0.9270	30.4744	31.3517	32.3639	31.4358
240100	1.3557	0.9146	30.9481	32.5307	33.0821	32.1908
240101	1.1930	0.9146	28.5503	28.7121	29.5095	28.9269
240104	1.3000	1.1027	35.8839	36.0711	40.4033	37.5188
240106	1.6415	1.1027	33.9984	36.8942	39.4450	36.7952
240115	1.5182	1.1027	36.2788	37.5802	38.9388	37.6716
240117	1.2305	0.9673	29.0894	30.4437	29.6594	29.7231
240132	1.4186	1.1027	36.4252	37.0941	37.9072	37.1624
240141	1.1176	1.1027	34.2473	35.8696	37.1809	35.6971
240166	1.2510	0.9146	26.1732	27.3184	28.1765	27.2416
240187	1.2545	1.1027	30.9646	33.5186	33.4717	32.6497
240196	0.8864	1.1027	35.0345	35.4472	38.7978	36.4399
240206	0.8428	1.4448	*	*	*	*
240207	1.3525	1.1027	36.4569	37.7179	39.4085	37.8940
240210	1.3728	1.1027	36.5950	37.7064	38.2195	37.5323
240211	0.6922	0.9958	16.6158	16.1460	16.5163	16.4219
240213	1.4249	1.1027	37.4608	38.4222	39.6158	38.5555
250001	2.1543	0.8125	24.3404	26.7079	28.0700	26.4339
250002	0.9292	0.8035	25.0342	31.2353	32.6776	29.5266
250004	1.8180	0.8981	24.8086	29.1096	30.0764	27.9177
250006	1.1385	0.8981	27.0511	26.9193	29.3899	27.7903
250007	1.1775	0.8923	29.3479	32.6672	31.9040	31.2803
250009	1.4344	0.8379	24.9118	25.9247	27.4133	26.1295
250010	1.0254	0.7738	22.7988	23.8749	24.5667	23.7460

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
250012	0.9436	0.9213	26.4110	29.8873	27.8154	28.0019
250015	1.3891	0.7738	22.3685	22.7775	24.6835	23.2714
250017	0.9972	0.7738	25.7404	25.5007	22.3075	24.4789
250018	0.7464	0.7738	19.1108	19.5527	20.4538	19.7094
250019	1.6160	0.8923	27.7230	28.4743	30.6079	28.9597
250020	0.9777	0.7738	23.1521	26.9602	27.3319	25.8108
250023	0.8903	0.8350	19.5081	22.2932	17.2321	19.5475
250025	1.1249	0.7738	23.0555	26.0579	25.2972	24.7574
250027	0.9255	0.7738	32.5451	26.7593	26.0044	28.1387
250031	1.3465	0.8125	26.7507	28.6356	29.2948	28.1906
250034	1.6373	0.8981	27.9279	29.3365	30.0088	29.1234
250035	0.7907	0.7738	20.5251	24.0653	21.6802	22.1592
250036	0.9473	0.8182	22.5676	22.6781	24.7319	23.3935
250038	0.8901	0.8125	30.7960	27.1958	27.6152	28.2419
250040	1.6037	0.8350	26.2268	28.4423	29.0586	27.8924
250042	1.2263	0.8981	27.4610	25.8791	30.3623	27.9247
250043	1.0488	0.7738	21.1265	22.4618	22.6912	22.0994
250044	0.9899	0.7738	26.1732	26.9451	27.9188	27.0217
250048	1.5964	0.8125	27.6339	27.4186	27.6442	27.5667
250049	0.9434	0.7738	24.2227	24.2129	21.5835	23.2761
250050	1.2840	0.7738	22.4429	22.6843	23.7790	23.0068
250051	0.7692	0.7738	14.1662	15.6982	15.7373	15.2520
250057	1.2695	0.7738	22.9683	22.5524	25.9738	23.8179
250058	1.2848	0.7738	19.6720	20.4748	22.1248	20.7697
250059	0.9412	0.7738	25.5982	24.8145	23.7995	24.7437
250060	0.8138	0.7738	27.0354	31.0689	32.3114	29.8012
250061	0.8353	0.7738	25.1495	23.3006	22.9622	23.7108
250067	1.1274	0.7738	23.8027	28.2894	27.2284	26.3793
250069	1.6226	0.8022	23.4495	25.8456	27.7173	25.6762
250072	1.7556	0.8125	27.5791	30.5382	33.2443	30.4790
250077	0.9612	0.7738	19.6333	19.3962	20.7217	19.9362
250078	1.7165	0.8350	23.9598	26.5481	27.5440	26.0252
250079	0.8236	0.8125	46.0349	32.3758	33.2547	37.9283
250081	1.4366	0.8022	24.8281	23.1385	25.6748	24.4935
250082	1.5383	0.8311	25.6218	27.8096	29.4889	27.6785
250084	1.1549	0.7738	19.5694	20.1192	21.2261	20.3028
250085	0.9389	0.7738	24.6757	24.5765	25.8783	25.0289

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
250093	1.2675	0.7738	26.4351	27.0937	28.9844	27.5340
250094	1.6566	0.8350	25.4232	26.1331	28.4550	26.7033
250095	1.1011	0.8125	25.9021	30.7505	25.2111	27.0637
250096	1.2779	0.8125	27.7291	27.5206	29.1993	28.1437
250097	1.5766	0.8580	22.7916	23.6607	24.1451	23.5520
250099	1.4358	0.8125	27.5757	25.0076	26.7877	26.4479
250100	1.4971	0.8022	27.5484	28.2019	29.4874	28.4283
250102	1.5878	0.8125	25.5327	27.8758	27.2188	26.8670
250104	1.4298	0.8022	25.4008	26.3140	25.7731	25.8274
250112	0.9397	0.7738	27.4162	29.6978	23.5300	26.6029
250117	1.0807	0.8350	24.5706	26.0965	24.8866	25.2046
250122	1.1551	0.7738	23.4908	27.3606	31.2642	27.3826
250123	1.3700	0.8923	29.8299	29.5520	32.4487	30.5969
250124	0.8592	0.8125	21.9420	22.4247	23.9262	22.8076
250125	***	*	32.7411	29.0819	31.9629	31.3858
250126	1.0391	0.9213	25.2581	26.8712	26.7811	26.3514
250127	0.8051	1.4448	*	*	*	*
250128	1.0195	0.8184	23.5918	24.7051	26.7124	25.1932
250134	0.9778	0.8125	22.0846	40.7995	30.5066	30.6943
250136	1.0796	0.8125	27.1479	27.8270	30.6565	28.5419
250138	1.3635	0.8125	27.3132	27.0688	29.2021	27.8594
250141	1.5961	0.9213	33.4413	32.1496	31.6915	32.3561
250149	0.8744	0.7738	17.0964	17.2423	20.1488	18.0903
250151	0.6315	0.7738	*	17.3962	25.0894	22.4010
250152	0.9097	0.8125	28.5526	29.8216	30.9016	29.7410
250161	***	*	*	26.0070	*	26.0070
250162	1.0038	0.8937	*	*	31.4828	31.4828
260001	1.7887	0.8448	31.1866	28.6690	30.0120	29.9052
260004	0.9453	0.8127	23.9584	24.1764	25.5508	24.5784
260005	1.6662	0.9060	31.1050	33.1020	35.2618	33.2207
260006	1.5176	0.8127	33.8253	34.3548	36.2278	34.8344
260009	1.1928	0.8605	26.6685	26.2248	26.1705	26.3503
260011	1.6596	0.8605	31.2612	31.4415	31.7034	31.4717
260015	1.1557	0.8127	25.0250	25.1585	26.2721	25.5036
260017	1.3354	0.8605	26.2621	27.4586	29.5743	27.7703
260020	1.7611	0.9060	30.9599	32.0889	31.9904	31.7069
260021	1.4447	0.9060	19.5810	19.3770	32.4283	21.7242

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260022	1.4859	0.8261	25.9391	25.6866	26.7028	26.0941
260023	1.5492	0.9060	25.5899	26.7586	27.4201	26.6186
260024	1.1778	0.8127	20.7136	22.4347	22.9479	22.0397
260025	1.4225	0.8955	24.5042	24.4959	24.4546	24.4847
260027	1.8912	0.9558	31.0236	32.3066	33.7779	32.3722
260032	1.9415	0.9060	28.7183	29.8257	30.8428	29.7999
260034	0.9685	0.8127	28.7736	29.7821	29.4705	29.3435
260040	1.7603	0.8413	27.3680	28.5035	29.9909	28.6335
260047	1.4981	0.8127	27.2667	27.1986	27.8259	27.4384
260048	1.2788	0.9558	29.6969	30.1691	30.8650	30.2475
260050	1.0775	0.8127	27.8065	27.6085	33.8795	29.6615
260052	1.3299	0.9060	29.6998	31.5722	32.2076	31.2112
260057	1.0671	0.9558	23.8181	27.0128	27.1389	26.1324
260059	1.2757	0.8204	25.3025	26.9521	27.3419	26.5876
260061	1.1228	0.8127	23.6717	24.7824	27.0467	25.1434
260062	1.3726	0.9558	29.6156	30.7159	32.0976	30.8722
260064	1.4339	0.8216	21.4932	23.6002	25.8393	23.6092
260065	1.7126	0.8413	28.3411	29.9325	29.6384	29.3273
260068	1.7723	0.8261	28.1246	29.3972	29.5631	29.0347
260070	0.8779	0.8127	25.2997	26.2370	25.8550	25.8217
260074	1.2943	0.8261	28.6216	28.4171	29.3367	28.7901
260077	1.7066	0.9060	28.7204	28.9940	29.4958	29.0802
260078	1.2849	0.8127	23.1785	24.7794	25.1259	24.3417
260080	1.0588	0.8127	18.6813	19.0041	19.1541	18.9629
260081	1.6605	0.9060	32.0799	34.8761	40.1198	35.5606
260085	1.6239	0.9558	29.6514	30.4727	31.6239	30.5668
260091	1.5674	0.9060	30.2636	32.9623	33.9609	32.4273
260094	1.6223	0.8413	25.1491	27.0127	27.2078	26.4777
260095	1.5411	0.9558	29.9090	30.9142	30.5602	30.4766
260096	1.6341	0.9558	32.9383	33.1804	34.9570	33.7008
260097	1.1617	0.8427	27.3129	28.2444	28.5379	28.0218
260102	1.0526	0.9558	30.7678	29.1467	30.1752	29.9874
260104	1.7078	0.9060	29.5891	32.0122	33.6904	31.7812
260105	1.8595	0.9060	32.4292	33.4278	35.1672	33.6282
260107	***	*	29.7775	38.3668	*	33.8526
260108	1.8751	0.9060	28.5654	30.1064	31.5495	30.0747
260110	1.6558	0.8810	28.0381	28.5364	30.1062	28.9080

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260113	1.2656	0.8380	23.0826	23.6758	25.6538	24.1544
260115	1.2365	0.9060	25.5658	26.5268	27.1964	26.4347
260116	1.0191	0.8380	22.5536	25.1758	27.7471	24.8978
260119	1.3362	0.8363	31.5003	26.4382	26.5894	27.9902
260137	1.7978	0.8448	31.4091	28.3521	29.0069	29.4979
260138	2.0048	0.9558	31.7582	33.4156	34.9809	33.4163
260141	2.0499	0.8261	26.6684	28.3492	28.1099	27.7524
260142	1.2469	0.8127	22.8205	25.0940	24.1327	24.0438
260147	0.8251	0.8127	22.9689	22.8326	25.3191	23.5737
260159	***	*	24.3027	25.5039	26.0684	25.2758
260160	1.0383	0.8271	26.6715	27.9585	25.0259	26.6874
260162	1.4325	0.9060	30.5761	32.3673	33.0717	32.0297
260163	1.2350	0.8214	23.8644	25.0443	26.1076	25.0496
260166	***	*	29.5259	30.6020	*	30.0575
260175	1.0460	0.9558	25.7069	26.5767	28.1661	26.8058
260176	1.7475	0.9060	30.6205	32.4957	33.1495	32.1198
260177	1.3018	0.9558	29.0815	31.1662	33.9925	31.4147
260178	1.9849	0.8261	26.9902	28.9170	29.8616	28.6265
260179	1.5711	0.9060	29.6316	30.3276	30.8119	30.2731
260180	1.7531	0.9060	30.7336	31.4721	32.7989	31.6539
260183	1.6167	0.8810	31.4916	32.2621	31.3742	31.7100
260186	1.5186	0.8605	29.1874	30.8706	32.4493	30.8711
260190	1.3538	0.9558	30.9003	32.2069	34.1815	32.3839
260191	1.5869	0.9060	27.8648	28.7185	29.0100	28.5516
260193	1.3548	0.9558	29.5436	30.5190	31.7196	30.5601
260195	1.4152	0.8127	25.0294	25.6697	26.6828	25.8073
260198	***	*	27.9093	31.4660	*	29.5529
260200	1.4152	0.9060	30.5032	32.0910	35.5276	32.9288
260207	1.1898	0.8413	23.6392	22.8308	22.7884	23.0797
260209	1.0738	0.8605	26.4203	33.7185	32.9213	30.8380
260210	1.2999	0.9060	36.4055	33.5701	35.4741	35.1652
260211	1.3016	0.9558	37.1557	42.4297	36.1850	38.3836
260214	1.3113	0.9558	31.0175	31.7957	34.1199	32.2663
260216	1.3206	0.9558	*	32.4039	33.4387	32.9968
260217	***	*	*	12.2879	*	12.2879
260219	1.3400	0.9060	*	*	30.7118	30.7118
260220	***	*	*	*	28.4885	28.4885

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260221	2.0760	0.8413	*	*	*	*
260222	3.1344	0.9558	*	*	*	*
260223	2.1186	1.0377	*	*	*	*
270002	1.1098	0.8439	28.3379	26.9419	28.2480	27.8202
270003	1.2908	0.8439	28.0543	28.5127	29.8638	28.8333
270004	1.7281	0.8944	28.5869	29.4694	31.2252	29.8125
270012	1.6404	0.8618	28.0672	27.9087	28.8521	28.2738
270014	2.0243	0.8811	28.2582	30.1101	30.2981	29.5713
270017	1.3880	0.8618	29.3542	29.4260	31.2231	30.0045
270023	1.6600	0.8811	28.1896	30.9908	31.5012	30.2124
270032	1.0183	0.8439	21.6360	21.5106	23.5705	22.2266
270049	1.8451	0.8944	29.8891	31.3941	31.2349	30.8507
270051	1.4506	0.8618	29.3941	29.1163	30.1070	29.5459
270057	1.4282	0.8439	28.3627	29.5317	31.6476	29.8918
270074	0.9307	1.4446	*	*	*	*
270086	1.4090	0.8439	21.9017	27.3995	29.1257	26.4704
270087	1.5197	0.8439	24.9197	24.2168	24.9946	24.6957
280003	1.8427	0.9490	32.3780	33.7700	34.2000	33.4257
280009	1.8904	0.9490	28.1559	31.9280	33.6269	31.2504
280013	1.7682	0.9554	30.3120	31.9793	32.8493	31.7431
280020	1.6813	0.9490	29.4831	30.3731	32.3597	30.7314
280023	1.4338	0.9490	30.0717	31.9420	31.3884	31.1400
280030	1.8814	0.9554	31.8758	33.4544	34.0104	33.0874
280032	1.4305	0.8886	25.6549	25.8707	27.6089	26.3994
280040	1.6949	0.9554	30.7406	32.1005	32.7707	31.9093
280060	1.7924	0.9554	30.4625	32.0607	33.5256	32.0484
280061	1.4381	0.8886	28.9591	29.2231	30.8542	29.7095
280065	1.2973	0.9418	29.5470	30.1143	30.8900	30.1783
280077	1.3795	0.9490	29.9223	29.7362	31.3194	30.3231
280081	1.6286	0.9554	28.9696	31.0768	35.8382	31.9389
280105	1.2687	0.9554	30.0472	33.3196	33.1407	32.1834
280111	1.1463	0.8886	28.3541	29.0865	29.9691	29.1189
280119	0.8685	1.4448	*	*	*	*
280123	***	*	20.2741	20.6384	29.1514	22.7020
280125	1.5076	0.8968	24.7466	25.1212	30.7311	26.8386
280127	1.9295	0.9490	26.5659	28.4607	27.8198	27.6863
280128	2.7835	0.9490	27.1024	19.2781	30.1879	25.4888

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
280129	2.0282	0.9554	27.9511	30.4258	30.9589	29.8728
280130	1.4549	0.9554	29.9645	32.4243	33.1336	31.9744
280131	2.1542	0.9554	*	*	*	*
290001	1.7980	1.0439	33.3318	32.3610	34.3377	33.3434
290002	0.8656	0.9960	22.7362	25.4458	22.9980	23.6418
290003	1.8020	1.1811	34.6433	36.8494	40.5365	37.2945
290005	1.5573	1.1811	34.2373	34.2514	36.3971	34.9747
290006	1.1041	1.0439	33.3243	32.9232	35.2729	33.8405
290007	1.8733	1.1811	41.2395	44.0851	42.0134	42.4287
290008	1.2259	0.9555	33.2473	36.1620	38.0995	35.8471
290009	1.8183	1.0439	34.2103	38.6692	40.9685	37.9159
290012	1.3732	1.1811	38.3731	38.1494	39.8936	38.8324
290019	1.6158	1.0439	32.2817	34.3215	35.6893	34.1535
290020	0.9789	0.9555	27.2908	25.3592	28.1710	26.9891
290021	1.6573	1.1811	36.8728	39.5976	41.5629	39.3340
290022	1.7355	1.1811	38.8262	40.9896	41.3493	40.4278
290027	0.8303	0.9555	29.1123	25.1315	17.5194	22.5706
290032	1.4270	1.0439	36.9175	38.9632	37.5999	37.8103
290039	1.6578	1.1811	34.6359	37.5722	41.3057	37.8449
290041	1.4861	1.1811	38.4445	40.0602	42.8383	40.5654
290045	1.7861	1.1811	38.2560	38.5440	40.6077	39.1861
290046	1.5403	1.1811	38.3112	41.5550	42.1303	40.8035
290047	1.7100	1.1811	35.6381	38.6892	41.6528	38.6969
290049	1.4003	1.0439	33.4278	33.2014	34.9166	33.8543
290051	2.0280	1.0282	32.5277	37.2727	37.4812	35.6526
290053	1.7043	1.1811	*	*	41.7596	41.7596
290054	1.3973	1.1811	*	*	*	*
290055	1.5038	1.0282	*	*	*	*
300001	1.4814	1.0054	31.0122	31.4533	31.9222	31.4790
300003	2.0987	1.0054	37.7246	37.3007	37.8482	37.6390
300005	1.4367	1.0054	28.8402	29.4927	32.0379	30.1494
300011	1.3554	1.0990	33.0785	32.7459	35.9010	33.9466
300012	1.4793	1.0990	33.0569	34.8519	34.3089	34.0963
300014	1.2376	1.0218	30.7735	32.8211	33.7545	32.5359
300017	1.4332	1.1021	33.4164	35.2028	37.5444	35.3995
300018	1.3748	1.0218	31.5028	32.7008	33.9529	32.7460
300019	1.3351	1.0258	28.3114	30.5332	31.7382	30.2375

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
300020	1.4207	1.0990	32.4655	34.7678	36.3083	34.5838
300023	1.4607	1.0054	32.3202	34.2636	35.1291	33.9582
300029	1.8966	1.1021	32.0033	35.3112	36.0190	34.4466
300034	1.8501	1.0990	33.5537	33.7397	32.8443	33.3569
310001	1.8394	1.2884	41.4946	44.8619	50.6238	45.4383
310002	1.8317	1.2619	37.9484	39.7599	41.2456	39.6858
310003	1.3084	1.2884	40.1543	39.8679	42.8065	40.9664
310005	1.3923	1.1099	34.7657	34.4087	36.0844	35.0992
310006	1.4947	1.2884	30.4296	29.1025	36.9201	33.0307
310008	1.4134	1.2884	34.3268	36.2903	37.2702	35.9673
310009	1.4910	1.2619	35.4624	37.9098	37.8328	37.0580
310010	1.3390	1.1069	36.0823	34.1071	34.7174	34.9269
310011	1.3734	1.1069	37.4855	34.0850	38.0642	36.5086
310012	1.5578	1.2884	41.9630	41.3814	44.1956	42.5328
310013	***	*	32.9488	*	*	32.9488
310014	1.9878	1.1069	35.0124	39.7527	42.5981	39.1445
310015	1.9757	1.2619	40.8229	39.5076	41.0862	40.4747
310016	1.3519	1.2884	41.0363	39.7563	42.6321	41.1071
310017	1.3342	1.2619	35.9806	34.8881	36.6814	35.8577
310018	***	*	32.6956	33.5069	33.6869	33.3032
310019	1.5578	1.2884	31.8930	34.6618	36.9116	34.4783
310020	***	*	38.4266	34.8440	33.1591	35.6399
310021	1.5817	1.1069	32.2064	33.2554	32.9745	32.8103
310022	1.3683	1.1069	32.8079	32.8154	35.0037	33.5940
310024	1.4947	1.1099	36.8666	34.7011	38.7731	36.8133
310025	1.4049	1.2884	32.1481	35.2564	40.8475	35.5411
310026	***	*	30.1321	31.9905	*	31.0489
310027	1.5531	1.1099	34.6471	34.1653	35.4202	34.7452
310028	1.2605	1.1099	34.8332	37.2987	38.5629	36.9482
310029	1.7816	1.1069	35.2084	36.5179	37.3225	36.3377
310031	2.6733	1.1069	39.5911	38.2643	39.1387	39.0033
310032	1.4461	1.1069	35.2402	35.8019	38.1019	36.3949
310034	1.4950	1.1069	36.8614	37.1191	38.7316	37.5645
310037	***	*	40.4642	44.3134	40.6768	41.8620
310038	1.8962	1.2619	39.8707	40.7395	41.0737	40.5745
310039	1.3494	1.2619	32.6425	33.4253	37.6948	34.5052
310040	1.2885	1.2884	41.2246	38.3232	42.0647	40.5945

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
310041	1.3677	1.1069	35.2009	34.4308	35.9905	35.2159
310044	1.4058	1.1069	33.5868	35.9981	36.7851	35.4384
310045	1.6751	1.2884	39.2097	40.3222	39.4667	39.6718
310047	1.3605	1.1069	37.7220	38.1213	38.6544	38.1625
310048	1.3744	1.1099	34.5256	33.9641	35.1089	34.5372
310050	1.3717	1.2619	37.9214	32.5213	36.1607	35.4032
310051	1.5361	1.1099	39.7671	37.9104	41.4326	39.7291
310052	1.4235	1.1069	36.5494	36.2042	36.6736	36.4774
310054	1.3353	1.2619	38.2432	37.2851	38.6073	38.0262
310057	1.4774	1.1069	34.2052	32.8649	33.3760	33.4433
310058	1.0417	1.2884	30.4436	32.1349	27.4856	30.0784
310060	1.4272	1.1069	27.9134	30.4626	31.0602	29.7917
310061	1.3306	1.1069	33.5586	33.6084	36.9685	34.7294
310063	***	*	38.1481	36.7131	40.5744	38.4253
310064	1.6138	1.1069	39.8091	39.9456	39.4518	39.7314
310069	1.2782	1.1069	35.1376	36.9367	38.6358	36.8960
310070	1.4374	1.2619	36.9999	36.8951	38.3936	37.4045
310073	1.8090	1.1069	36.9249	37.5317	38.0676	37.5047
310074	1.3788	1.2884	39.0729	35.9044	36.5051	37.2159
310075	1.3708	1.1069	33.5253	33.8979	36.8738	34.7688
310076	1.7422	1.2619	38.1671	39.0325	41.7283	39.6466
310081	1.4281	1.1069	31.7981	32.1241	34.1491	32.7041
310083	1.5302	1.2619	28.3406	28.2875	32.3793	29.6429
310084	1.2977	1.1069	34.9626	34.3130	35.9514	35.1066
310086	1.2760	1.1069	30.9467	31.4837	32.6634	31.7177
310088	1.1089	1.1069	31.2437	28.1703	30.2907	29.8993
310090	***	*	33.9174	36.2502	39.0484	36.2524
310091	1.2160	1.1069	35.2913	34.8679	36.3009	35.4738
310092	1.5401	1.1069	32.8431	34.8028	35.8723	34.4902
310093	***	*	32.3860	33.4460	31.7831	32.5380
310096	1.7501	1.2619	34.2014	36.3201	35.9746	35.5053
310105	***	*	32.0277	31.3423	38.1225	33.7325
310108	1.5387	1.2619	36.2848	38.3403	40.4235	38.3602
310110	1.3629	1.1069	35.6825	36.5227	34.9354	35.6895
310111	1.3887	1.1069	36.0748	38.3519	38.6478	37.7170
310112	1.3763	1.1069	34.5337	33.6207	34.5131	34.2210
310113	1.3519	1.1069	35.0245	38.0066	38.4702	37.2154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
310115	1.4081	1.1069	32.1197	33.7061	34.3696	33.4228
310116	1.3231	1.2884	27.8677	35.3805	35.7518	32.7295
310118	1.3491	1.2884	32.8286	33.2234	33.7344	33.2605
310119	1.9233	1.2619	41.2997	46.1339	47.1035	44.7858
310120	1.0481	1.1099	35.1661	36.3365	37.6331	36.3759
310126	***	*	34.3189	*	*	34.3189
310127	***	*	*	40.1255	*	40.1255
320001	1.8271	0.9638	31.4193	33.6433	35.9775	33.8378
320002	1.5849	1.0788	34.1610	35.6036	37.4477	35.7737
320003	1.0965	1.0400	31.5792	31.4445	34.6790	32.5200
320004	1.3353	0.9030	28.2407	30.5543	31.0096	29.9078
320005	1.6317	0.9505	25.2168	26.4658	27.9464	26.5665
320006	1.2566	0.9505	28.5177	31.6888	35.2623	31.7638
320009	1.7026	0.9638	31.3296	31.7240	33.1269	32.2269
320011	1.1092	0.9374	28.9951	30.6151	31.5915	30.3549
320013	1.2176	1.0400	31.2890	31.7159	31.8550	31.6268
320014	1.0148	0.9183	30.4803	29.8578	33.1461	31.2305
320016	1.1858	0.9030	26.6392	27.7121	27.8593	27.4337
320017	1.3865	0.9638	30.5787	30.9261	28.3807	29.6659
320018	1.5868	0.9207	28.3465	29.9038	32.8908	30.3587
320019	***	*	28.7067	31.8205	34.4963	30.4182
320021	1.5923	0.9638	29.6464	31.3577	32.8369	31.4496
320022	1.1128	0.9030	27.5152	28.7195	30.9229	28.9228
320030	0.9864	0.9030	25.5267	28.5145	29.5507	27.9621
320033	1.2665	1.0400	30.1846	32.8631	36.8262	33.1229
320037	1.1970	0.9638	27.8982	28.6968	29.0394	28.5512
320038	1.2537	0.9030	31.6526	33.2147	34.1644	33.0257
320057	0.8901	1.4448	*	*	*	*
320058	0.7912	1.4448	*	*	*	*
320059	1.0293	1.4448	*	*	*	*
320060	1.0719	1.4448	*	*	*	*
320061	1.0731	1.4448	*	*	*	*
320062	0.8817	1.4448	*	*	*	*
320063	1.2855	0.9315	27.4946	30.2997	31.3336	29.7847
320065	1.2319	0.9030	26.9130	27.9999	31.2804	28.6457
320067	0.8536	0.9030	25.4121	23.6677	26.3413	25.1468
320069	1.0613	0.9030	25.3151	26.5521	25.6533	25.8355

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
320070	0.9578	1.4448	*	*	*	*
320074	1.3254	0.9638	28.8088	29.8317	31.0548	30.0014
320079	***	*	31.5661	30.3600	*	30.9560
320083	2.2519	0.9638	32.9476	35.1125	33.6069	33.8474
320084	0.8797	0.9030	24.2902	25.9161	27.1350	25.8609
320085	1.7238	0.9207	28.4537	28.7114	30.1280	29.0969
320086	1.3497	0.9030	*	*	25.1198	25.1198
320087	1.6719	1.0788	*	*	42.5428	42.5428
320088	2.4348	0.9207	*	*	34.8348	34.8348
330002	1.7166	1.3154	34.7270	35.3553	37.0389	35.6963
330003	1.4425	0.8708	26.8363	27.7173	28.8520	27.8126
330004	1.3751	0.9785	30.3221	30.8305	31.6848	30.9524
330005	1.6498	0.9628	33.2851	34.1763	35.4979	34.3373
330006	1.4087	1.3154	36.3305	38.6645	38.8190	37.9639
330008	1.1596	0.9628	26.2141	26.7882	28.4993	27.1558
330009	1.4682	1.3154	41.3797	42.4137	43.3382	42.4122
330010	1.1603	0.8487	20.5805	24.3033	*	22.4266
330011	1.2668	0.8932	26.8269	29.2672	30.3716	28.8455
330013	1.9518	0.8708	28.8039	29.2399	30.3522	29.4870
330014	1.4172	1.3154	46.3170	48.1054	48.9173	47.8284
330019	1.2184	1.3154	44.5669	46.8153	47.5751	46.3311
330023	1.5195	1.2884	37.5135	40.9595	42.7458	40.4809
330024	1.8856	1.3154	44.8070	46.2954	46.9066	46.0301
330025	1.1126	0.9628	24.2702	26.5550	27.7959	26.2089
330027	1.3420	1.2884	45.9571	49.0573	51.4887	48.8103
330028	1.5496	1.3154	38.0149	38.7770	44.2973	40.0572
330029	0.6085	0.9628	22.9332	23.7555	23.2845	23.3244
330030	1.2366	0.8708	25.5089	27.4344	29.0646	27.3460
330033	1.1516	0.8643	25.0215	26.7551	25.6393	25.7911
330036	1.2446	1.3154	30.4659	31.2701	33.0839	31.6283
330037	1.1595	0.8708	23.4915	24.4428	25.1766	24.3854
330041	1.3783	1.3154	37.1651	41.2299	45.4010	40.9876
330043	1.5215	1.2591	40.6094	42.4560	43.3176	42.1465
330044	1.3451	0.8737	28.2638	29.4872	31.0628	29.6090
330045	1.5074	1.2591	41.6565	44.7551	43.4805	43.2898
330046	1.5094	1.3154	52.2397	53.4532	55.0516	53.5982
330047	1.3009	0.8487	22.9948	27.4392	27.9776	26.2104

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330049	1.6219	1.1418	34.9740	38.0110	39.1050	37.4092
330053	1.0453	0.8708	20.1303	21.4837	22.9142	21.4899
330055	1.6466	1.3154	44.2343	44.6905	45.0891	44.6857
330056	1.5790	1.3154	39.9662	40.5499	43.3731	41.2870
330057	1.8056	0.8708	30.1821	30.5006	31.3091	30.6714
330058	1.4159	0.8708	23.6296	25.3712	26.6416	25.2427
330059	1.6093	1.3154	45.3691	47.7115	48.5102	47.2325
330061	1.2404	1.3154	37.8649	38.8790	38.2257	38.3275
330064	1.4200	1.3154	41.5737	39.5994	39.7532	40.3486
330065	1.1305	0.9628	26.2288	28.6809	29.2490	28.0535
330066	***	*	27.2085	30.7011	31.6665	29.8079
330067	1.4686	1.1418	30.7537	31.5572	33.4719	31.8968
330072	***	*	41.4605	40.5965	41.2397	41.0975
330073	1.1842	0.8708	25.1392	24.8055	27.0827	25.6766
330074	1.1789	0.8708	23.1016	24.6973	24.5262	24.0899
330075	1.1415	0.9710	23.7522	27.5360	29.7333	26.9519
330078	1.4769	0.9628	27.6682	30.8157	31.7996	30.0981
330079	1.4095	0.9328	27.9479	28.7349	30.3415	29.0021
330080	1.2278	1.3154	40.2067	47.4529	47.6661	45.2191
330084	1.0795	0.8420	27.3434	28.8661	32.3490	29.4885
330085	1.1543	0.8420	27.1707	27.7050	29.8188	28.2639
330086	1.4037	1.3154	40.9768	44.0362	43.8907	42.9617
330088	1.0424	1.2591	37.4716	41.8635	40.8115	40.0302
330090	1.5852	0.9187	27.7306	29.5626	31.1822	29.4923
330091	1.3864	0.9628	28.3034	30.9457	31.7515	30.3752
330094	1.2966	1.0158	28.6213	33.0706	34.7858	32.0911
330096	1.2839	0.8420	24.7895	24.8667	25.8292	25.1613
330100	1.0060	1.3154	39.3170	38.6625	42.2645	40.0975
330101	1.9953	1.3154	45.5412	49.6431	49.8588	48.3746
330102	1.5567	0.9628	27.2543	31.6270	31.8101	30.2074
330103	1.2588	0.8551	25.4919	26.1064	27.2392	26.3017
330104	1.4546	1.3154	36.5894	38.4254	39.2321	38.0457
330106	1.7129	1.2884	48.2903	47.2240	50.3199	48.5977
330107	1.2256	1.2591	38.0262	40.2541	42.4304	40.1994
330108	1.1028	0.8540	25.3023	25.5480	26.9810	25.9259
330111	0.9381	0.9628	23.2134	25.1572	26.0179	24.6747
330115	1.1378	0.9710	24.3898	27.0362	25.4507	25.6316

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330119	1.8188	1.3154	41.2365	43.8894	44.0249	43.0193
330125	1.7757	0.8708	29.4817	30.4389	30.4103	30.1168
330126	1.3867	1.2884	37.7807	40.0542	41.7981	39.8971
330127	1.4712	1.3154	45.2554	51.8817	48.5274	48.5452
330128	1.2873	1.3154	43.3437	41.7875	46.9809	44.0332
330132	1.0753	0.8551	22.1452	23.4437	23.9298	23.1468
330133	***	*	39.9025	*	*	39.9025
330135	1.2525	1.2060	33.2314	35.3624	39.4523	36.0995
330136	1.6306	0.8708	25.4198	27.9525	28.3358	27.2668
330140	1.8705	0.9710	31.1333	32.7905	33.3826	32.4461
330141	1.3455	1.2591	39.1733	41.4127	44.4198	41.7713
330144	0.9644	0.8454	24.9304	26.0623	28.4224	26.4223
330151	1.2456	0.8454	21.6339	23.4664	23.7227	22.9394
330152	1.4485	1.3154	39.5754	45.9310	54.7885	46.5567
330153	1.7004	0.8708	28.9944	31.7611	31.6854	30.8216
330154	1.5936	*	*	*	*	*
330157	1.3987	0.9710	29.7622	30.2745	31.5462	30.5482
330158	1.8465	1.3154	39.5946	41.6800	45.4100	42.4088
330159	1.3174	0.9710	33.8484	35.6944	36.1910	35.2789
330160	1.5849	1.3154	39.0970	42.1789	42.6001	41.2794
330162	1.2954	1.3154	38.7638	39.3460	39.3481	39.1620
330163	1.0935	0.9628	28.6252	26.3050	28.3979	27.7803
330164	1.5397	0.8708	29.8458	30.3023	31.3949	30.5335
330166	0.8986	0.8420	22.8506	23.2773	24.1281	23.4282
330167	1.6650	1.2884	39.2421	40.8753	40.4764	40.2069
330169	1.4020	1.3154	47.5404	49.7924	52.6481	49.9729
330175	1.1395	0.8680	26.7883	28.2085	29.0736	28.0498
330177	0.9519	0.8420	23.4299	26.0397	26.3552	25.2331
330180	1.3073	0.8708	26.8658	28.0975	28.8360	27.9626
330181	1.4442	1.2884	46.2181	47.2523	47.5998	47.0087
330182	2.3077	1.2884	42.7962	46.6346	47.1719	45.5399
330184	1.4461	1.3154	39.7242	41.3935	44.1215	41.7428
330185	1.3245	1.2591	39.6724	41.3543	42.6846	41.2528
330188	1.3394	0.9628	29.7318	30.7222	31.9349	30.8079
330189	0.9639	0.8708	25.8125	26.4233	27.1290	26.4668
330191	1.3966	0.8708	28.2949	29.3753	30.8219	29.5362
330193	1.5971	1.3154	40.0280	40.7257	41.4653	40.7612

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330194	1.7160	1.3154	49.8886	49.9208	51.5125	50.4577
330195	1.6426	1.3154	43.3213	46.0878	46.8783	45.3774
330196	1.3574	1.3154	38.6949	42.8106	47.1254	42.9572
330197	1.1361	0.8420	26.5525	27.6437	28.8743	27.7160
330198	1.5031	1.2884	35.8715	37.9641	39.0864	37.7000
330199	1.1339	1.3154	39.4076	47.5059	46.3505	44.4308
330201	1.8227	1.3154	46.5114	51.2179	54.5822	50.6852
330202	1.3722	1.3154	38.7624	42.1074	46.7852	42.6301
330203	1.5060	0.9710	34.6525	33.9161	34.8968	34.4914
330204	1.3905	1.3154	39.5324	44.8153	45.9057	43.4038
330205	1.3126	1.2060	35.3792	37.0171	39.7040	37.4547
330208	1.2411	1.3154	37.1735	38.7279	40.4900	38.7610
330211	1.2386	0.8420	24.9432	25.6929	25.1977	25.2864
330213	1.0549	0.8737	28.5370	30.0957	30.7737	29.8133
330214	1.9522	1.3154	43.3229	43.6872	45.3214	44.1777
330215	1.3738	0.8420	26.3978	28.0026	29.8652	28.0726
330218	1.1081	0.9710	28.4113	28.4369	28.6896	28.5177
330219	1.7911	0.9628	33.2147	38.3321	35.2787	35.5523
330221	1.6164	1.3154	42.5486	40.5201	40.5359	41.2446
330222	1.4126	0.8724	28.7858	30.5142	30.9231	30.1149
330223	0.9881	0.8420	27.1970	28.2638	29.7060	28.4078
330224	1.3051	1.1246	30.4784	32.4518	32.2402	31.7207
330225	1.2507	1.2884	32.9036	33.7052	32.9394	33.1790
330226	1.5413	0.8708	26.3685	25.7981	25.8056	25.9824
330229	1.2515	0.8420	23.9243	24.9977	25.8926	24.9413
330230	***	*	39.3863	39.5043	38.2724	39.1655
330231	1.1081	1.3154	48.9021	49.1983	55.0629	51.0168
330232	1.3400	0.8708	27.9615	28.7263	30.4424	29.0437
330233	1.7151	1.3154	40.8539	43.4873	45.0313	43.1279
330234	2.3642	1.3154	49.8804	55.2159	52.8431	52.7054
330235	1.1918	0.8420	30.8034	31.2218	32.2728	31.3938
330236	1.5342	1.3154	42.6205	45.0321	46.2233	44.6274
330238	1.1263	0.8708	23.3953	24.7086	25.0088	24.3863
330239	1.2644	0.8420	24.6391	24.7255	25.3756	24.9143
330240	1.2759	1.3154	41.6132	42.5871	39.9681	41.3705
330241	1.8864	0.9710	32.9275	34.7013	35.6452	34.4408
330242	***	*	38.7875	40.2224	38.6084	39.2370

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330245	1.7049	0.8737	28.6698	29.3183	29.9976	29.3388
330246	1.4001	1.2591	35.9577	39.4705	37.8934	37.7571
330247	***	*	41.3465	39.8390	41.3991	40.8503
330249	1.3877	0.9710	26.9856	29.4003	31.3898	29.2579
330250	1.4215	1.0071	29.6186	32.1740	32.6642	31.4918
330259	1.4278	1.2884	39.0213	38.5914	37.9733	38.5494
330261	1.2872	1.3154	38.0216	37.9563	43.0206	39.7053
330263	0.9364	0.8420	24.2125	25.5991	27.1890	25.6737
330264	1.4015	1.2060	32.5050	35.1876	37.0730	34.9405
330265	1.2783	0.8708	22.7433	22.8141	23.4393	23.0082
330267	1.5186	1.3154	35.3907	38.1619	39.3105	37.7127
330268	0.9270	0.8420	23.9135	25.7738	27.2044	25.6557
330270	2.1604	1.3154	52.3154	55.7360	54.4915	54.2881
330273	1.4195	1.3154	39.7880	41.3568	43.8576	41.7263
330276	1.0974	0.8456	27.0445	28.5781	29.1322	28.2518
330277	1.3453	0.9187	30.8156	30.8543	30.9283	30.8668
330279	1.6990	0.9628	31.2393	33.7210	34.1573	33.0755
330285	1.9158	0.8708	31.8987	33.0830	34.8538	33.3318
330286	1.3682	1.2591	38.8556	40.3250	42.5791	40.6255
330290	1.6635	1.3154	39.8036	43.2989	45.9549	43.0520
330304	1.3128	1.3154	39.4632	39.7987	39.8891	39.7160
330306	1.5933	1.3154	39.0409	40.3216	43.4869	40.9711
330307	1.3162	0.9777	30.8121	33.6277	34.1345	32.8690
330314	***	*	22.6885	38.7241	*	24.3594
330316	1.3911	1.3154	37.9357	40.3783	41.6082	39.9746
330331	1.3669	1.2884	44.1734	44.3947	46.9048	45.1731
330332	1.3212	1.2884	38.6932	40.8557	43.4228	41.0514
330339	***	*	25.0057	26.8982	28.5075	26.7655
330340	1.2054	1.2591	38.4726	38.4180	42.2175	39.7075
330350	1.5307	1.3154	44.2389	47.8575	48.0009	46.7458
330353	1.4414	1.3154	46.0215	45.8432	49.5882	47.1722
330354	1.9646	*	*	*	*	*
330357	1.5294	1.3154	40.2132	45.4617	46.6428	43.1989
330372	1.3511	1.2884	37.0323	40.3348	43.4028	40.1441
330385	1.1384	1.3154	47.4017	51.5393	45.1489	48.1275
330386	1.3008	1.1332	32.9990	35.2560	36.5454	34.8018
330389	***	*	37.5908	39.3586	*	38.5126

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330390	1.5026	1.3154	38.7652	35.4546	38.7532	37.4670
330393	1.7670	1.2591	38.9324	40.1511	41.2486	40.1584
330394	1.6358	0.8932	28.8074	30.5684	31.6244	30.3603
330395	1.3609	1.3154	50.1316	41.6484	45.4826	45.3889
330396	1.5484	1.3154	39.1956	41.6293	44.4691	41.8352
330397	1.4662	1.3154	41.1682	41.0651	42.6933	41.6049
330399	1.2742	1.3154	39.8023	41.7487	43.7557	41.7446
330401	1.3844	1.2591	41.7839	47.0780	45.2281	44.6412
330403	0.8761	0.8708	28.7282	26.7473	23.7571	26.0020
330404	1.1578	1.3154	36.1069	36.8792	36.7400	36.5676
330405	1.1290	1.3154	35.2720	38.6588	39.7124	37.3537
330406	1.1795	0.8708	28.2733	28.0950	29.0800	28.3975
330407	***	*	*	*	22.8305	22.8305
340001	1.5740	0.9299	29.9718	30.6910	31.4272	30.7359
340002	1.8308	0.9055	30.7403	31.6973	32.7669	31.7640
340003	1.4893	0.8476	26.6831	28.0732	28.5497	27.8127
340004	1.5876	0.8974	27.9200	30.6110	31.1689	29.9152
340008	1.2878	0.8768	29.0661	30.7569	34.1051	31.2995
340010	1.4897	0.8476	29.5232	31.0327	32.4035	31.0271
340011	1.1201	0.8476	22.5152	23.6040	24.0602	23.4067
340012	1.2071	*	24.9271	*	*	24.9271
340013	1.2699	0.9162	26.9152	29.2509	27.6445	27.9355
340014	1.6864	0.8974	29.5350	29.4771	30.8373	29.9760
340015	1.4756	0.9162	30.0979	30.7573	28.8959	29.8838
340016	1.4468	0.8476	27.9651	27.2226	28.5561	27.9443
340017	1.4517	0.9055	28.4866	28.4785	30.0523	29.0201
340020	1.2373	0.8632	28.3461	30.5510	32.0755	30.2875
340021	1.5313	0.9162	31.3630	32.5625	31.4752	31.8018
340023	1.4538	0.9127	27.6921	29.5911	30.1104	29.1815
340024	1.3148	0.8653	26.9001	27.4770	28.5059	27.6241
340025	***	*	25.2846	25.8195	27.0389	26.0605
340027	1.2773	0.9192	26.6528	27.2788	27.9469	27.2947
340028	1.5908	0.9453	31.9872	31.7634	33.0069	32.2702
340030	2.1669	0.9662	31.2051	31.5786	33.0418	31.9615
340032	1.5602	0.9299	29.2080	29.3927	31.1516	29.9329
340035	1.0454	0.8476	26.0846	26.8821	28.5418	27.1710
340036	1.1481	0.9713	29.0646	29.9160	32.2510	30.4372

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
340037	1.3488	0.9162	30.5362	32.0484	32.2585	31.6367
340038	1.2142	0.8729	26.2600	26.9487	27.5626	26.9249
340039	1.3643	0.8974	29.5069	30.2952	30.5891	30.1244
340040	1.9443	0.9343	30.1280	31.3866	32.6226	31.4428
340041	1.5949	0.8650	27.1285	27.8408	26.9709	27.3113
340042	1.2562	0.8476	27.0597	27.0729	27.4651	27.2070
340047	1.8790	0.8974	28.7620	30.6701	31.8492	30.4241
340049	1.9406	0.9662	31.5555	35.4171	37.3166	34.8797
340050	1.3906	0.9238	29.2290	30.4447	30.6267	30.1189
340051	1.3116	0.8537	25.4981	25.4162	27.3196	26.0657
340053	1.6844	0.9299	30.8342	30.9274	32.3100	31.3844
340055	1.3835	0.8650	29.0116	29.5040	29.9587	29.5167
340060	1.1756	0.8996	26.8387	27.3403	27.6220	27.2840
340061	1.8918	0.9662	31.2910	33.4821	35.0126	33.3710
340064	1.3481	0.8476	25.0814	27.2184	23.8863	25.2967
340068	1.3615	0.8680	24.7409	27.3499	29.9975	27.4065
340069	1.8686	0.9662	32.2171	32.5361	34.5413	33.1296
340070	1.3306	0.8996	27.7679	29.0391	30.6796	29.1889
340071	1.1590	0.9713	29.7343	31.3756	33.3407	31.6507
340073	1.8342	0.9662	33.1054	33.2705	35.0550	33.8504
340075	1.4189	0.8650	26.8315	29.1504	29.2000	28.3921
340084	1.2918	0.9299	25.6885	27.4289	28.6175	27.2158
340085	1.3401	0.8996	29.1095	29.9176	30.6564	29.9103
340087	1.2638	0.8476	23.8360	25.0091	24.8627	24.5696
340090	1.4562	0.9713	28.3615	28.6805	30.2246	29.1062
340091	1.6471	0.8974	30.4371	31.2643	32.1069	31.2828
340096	1.2936	0.8996	26.5814	26.8103	28.8274	27.3932
340097	1.2417	0.8476	27.9810	29.8702	31.1005	29.7098
340098	1.6521	0.9299	31.3916	31.8472	32.6891	31.9928
340099	1.3129	0.8476	26.0077	28.1143	27.2332	27.0988
340104	***	*	19.9492	20.2901	22.6845	20.9674
340106	1.1483	0.8476	24.5154	24.4254	24.4668	24.4681
340107	1.1997	0.9123	27.3565	28.5859	31.3986	29.1909
340109	1.3875	0.8954	26.6479	28.6310	29.6145	28.2997
340113	2.0509	0.9299	32.3786	32.4983	33.7477	32.8917
340114	1.6329	0.9662	30.1207	32.3730	33.9019	32.1940
340115	1.6196	0.9662	28.0974	28.9265	30.1329	29.0563

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
340116	1.6601	0.8650	29.9447	30.8834	31.7109	30.8405
340119	1.5385	0.9299	27.2938	28.1090	27.5712	27.6658
340120	1.1905	0.8476	26.1465	26.6358	25.4889	26.0896
340121	1.2056	0.8476	25.1577	25.7488	27.4932	26.1656
340123	1.4033	0.8996	28.7150	29.9077	30.2556	29.6505
340124	***	*	25.7294	25.2498	*	25.5286
340126	1.4018	0.9713	30.6902	31.7266	32.8511	31.7775
340127	1.3442	0.9662	28.8675	30.8152	29.2765	29.6601
340129	1.4724	0.9162	31.7863	27.7470	28.6231	29.2827
340130	1.3943	0.9299	29.5294	30.4887	31.5667	30.5985
340131	1.5012	0.9192	29.6571	32.1743	32.7180	31.5487
340132	1.2123	0.8476	25.3264	25.9153	27.9450	26.4203
340133	1.0352	0.8795	26.8850	27.2630	27.7506	27.3138
340137	***	*	27.0874	28.8723	*	27.9808
340138	0.7851	0.9662	*	*	*	*
340141	1.7657	0.9264	29.3372	30.8628	32.7734	31.0073
340142	1.3540	0.8476	28.2413	28.4951	28.8034	28.5181
340143	1.6608	0.8650	29.3861	30.7162	30.7369	30.3039
340144	1.3389	0.9162	27.6548	26.5581	28.9693	27.6935
340145	1.3578	0.9162	28.0647	28.4230	30.2759	28.9487
340147	1.4283	0.9713	29.6960	30.2620	31.9805	30.6482
340148	1.5162	0.8974	27.9136	28.6607	29.4141	28.6790
340151	1.2488	0.8528	24.5782	25.9633	27.4868	26.0151
340153	2.2501	0.9299	29.8278	30.9065	31.9428	30.9177
340155	1.5111	0.9662	31.7570	31.6719	33.3228	32.2613
340156	0.9566	1.4446	*	*	*	*
340158	1.2800	0.9264	29.4110	29.2570	30.5810	29.7971
340159	1.2531	0.9662	28.1706	27.8427	28.4492	28.1630
340160	1.3305	0.8476	24.2016	24.9127	26.6329	25.2921
340166	1.4619	0.9299	29.9122	31.0779	32.0934	31.0482
340168	0.6198	0.9264	*	*	*	*
340171	1.2836	0.9299	31.1954	31.7831	32.9707	32.0444
340173	1.3664	0.9662	30.9843	30.9025	33.6286	31.9191
340183	1.4456	0.9299	30.1261	31.4691	33.8741	32.0540
340184	1.2205	0.9055	*	*	*	*
350002	1.9786	0.7641	23.6051	25.2966	25.6152	24.8333
350003	1.3396	*	24.5812	27.3546	*	25.9392

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
350006	1.5896	0.7451	23.4343	26.6508	24.5023	24.8210
350009	1.1530	*	23.9795	*	*	23.9795
350011	1.9178	0.8102	26.0201	27.3884	28.6631	27.4053
350015	1.7512	0.7641	22.9120	27.6960	27.5676	26.0667
350017	***	*	24.0968	*	*	24.0968
350019	1.7575	0.8034	24.9890	27.0960	28.0496	26.7628
350030	***	*	23.1023	*	*	23.1023
350063	0.9324	1.4448	*	*	*	*
350064	0.7461	1.4448	*	*	*	*
350070	1.7884	0.8102	26.2871	28.1430	27.2743	27.2399
360001	1.6025	0.9624	30.1038	31.8522	32.7842	31.5960
360002	1.4501	0.8696	25.2209	26.7549	28.6674	26.8773
360003	1.8677	0.9624	31.8976	31.9294	33.1679	32.3384
360006	1.9087	1.0163	31.8814	35.3579	37.9929	35.0514
360008	1.5052	0.8757	28.0202	28.5988	29.5464	28.7459
360009	1.6126	0.9254	28.2423	30.2452	30.8841	29.8023
360010	1.3386	0.8612	26.6040	27.3194	29.0985	27.6697
360011	1.4401	1.0025	29.9882	31.3142	31.2797	30.8745
360012	1.4610	1.0163	31.9837	32.9127	33.7117	32.8731
360013	1.1783	0.9254	30.2406	30.9331	32.0183	31.0838
360014	1.2374	1.0025	28.1811	28.9635	31.9691	29.7242
360016	1.5885	0.9624	30.2190	30.5892	31.9656	30.9288
360017	1.8785	1.0163	32.6006	34.8774	37.9269	35.0847
360019	1.3519	0.9082	28.8568	29.3536	29.9006	29.3780
360020	1.5714	0.9082	27.8079	29.5312	30.6901	29.3408
360025	1.4669	0.9246	28.4761	29.5329	30.0999	29.3797
360026	1.6064	0.9172	27.5757	27.3618	26.3380	27.0570
360027	1.5697	0.9082	29.9449	30.8898	32.5281	31.0972
360029	1.1553	0.9374	28.0191	29.0633	29.4172	28.8392
360032	1.3121	0.8555	27.2636	27.4896	29.0836	27.9439
360035	1.7082	1.0163	32.0858	32.5622	33.7737	32.7945
360036	1.2891	0.8917	29.9410	31.5027	32.2558	31.2400
360037	1.6216	0.9082	30.6552	31.5221	32.0751	31.4189
360038	1.7378	0.9624	31.3776	32.3095	34.0962	32.4982
360039	1.5460	0.8555	25.8216	27.3636	28.7284	27.2681
360040	1.2153	0.8942	26.7450	28.4404	29.8190	28.4196
360041	1.3782	0.9082	28.4439	29.3331	29.9816	29.2239

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360044	1.2307	0.8682	24.7698	25.7011	25.6594	25.3785
360046	1.3090	0.9624	28.2972	28.5624	28.9068	28.5940
360048	1.8571	0.9374	30.0390	33.3273	39.7450	34.2489
360051	1.7630	0.9172	29.4434	30.5937	31.1421	30.4107
360052	1.6740	0.9172	28.4731	29.8072	31.5097	29.8835
360054	1.5310	0.8757	23.6606	26.8828	27.5188	25.9621
360055	1.4571	0.9082	31.4794	31.2738	32.8952	31.8741
360056	1.5298	0.9624	31.3936	31.8378	33.3691	32.2230
360058	1.1411	0.8555	25.9295	27.7073	27.9521	27.1876
360059	1.7410	0.9082	30.6294	31.3956	32.6539	31.5860
360062	***	*	32.9025	35.2065	*	34.0497
360064	1.6958	0.8628	28.6101	28.5325	29.7002	28.9332
360065	1.2957	0.9082	31.5066	31.6781	32.9311	32.0490
360066	1.4780	0.9254	30.9652	32.1991	33.3925	32.2022
360068	1.9074	0.9374	28.6335	30.0212	30.0149	29.5525
360070	1.7211	0.8650	28.8739	30.0192	30.7774	29.8917
360071	1.1589	0.8590	25.7956	26.6139	29.0698	27.1686
360072	1.4371	1.0163	29.1514	29.8851	29.9298	29.6482
360074	1.4181	0.9374	28.0283	30.1333	30.4801	29.5360
360075	1.3041	0.9082	28.3930	29.8181	31.5315	29.9856
360076	1.6207	0.9624	29.5342	28.8462	39.7210	32.3956
360077	1.6129	0.9082	28.3022	26.2961	29.4388	28.0016
360078	1.3461	0.9082	27.3652	28.2973	29.8163	28.5296
360079	1.9369	0.9172	31.3132	32.0935	34.0345	32.4653
360080	1.2318	0.8555	21.8806	22.9825	23.4889	22.7871
360081	1.3978	0.9374	31.4293	33.2532	33.2079	32.6352
360082	1.3923	0.9082	30.5837	29.7447	31.0704	30.4761
360084	1.6721	0.8650	29.2489	29.2527	30.7559	29.7670
360085	1.9801	1.0163	33.1295	35.9664	36.9965	35.5221
360086	1.6162	0.9172	29.1579	31.9690	31.4898	30.8314
360087	1.5016	0.9082	28.6336	30.0084	31.6840	30.0619
360089	1.1498	0.8555	28.0779	28.5192	31.2561	29.2567
360090	1.4048	0.9374	29.2662	30.3175	30.9528	30.1599
360091	1.3254	0.9082	28.2009	29.6324	30.4266	29.4199
360092	1.3143	1.0163	28.0813	28.3576	30.1497	28.8462
360095	1.5618	0.9246	30.2138	30.0996	29.4352	29.8848
360096	1.1693	0.8626	27.9514	29.8687	30.9621	29.5853

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360098	1.4382	0.9082	26.5839	27.6752	29.8125	28.0156
360100	***	*	25.8143	25.9628	25.6754	25.8206
360101	1.4306	0.9082	30.6650	29.4661	30.1728	30.0962
360107	1.0926	0.8674	26.8180	29.9869	30.3832	29.1302
360109	1.1223	1.0025	30.4643	30.7873	32.3056	31.1780
360112	1.8127	0.9653	32.4403	34.6063	34.7090	33.9241
360113	1.3049	0.9624	30.3914	33.3293	33.4370	32.4622
360115	1.4149	0.9082	27.9711	29.0971	30.1635	29.1065
360116	1.2562	0.9624	26.8632	29.3122	29.7886	28.5973
360118	1.5008	0.8917	29.9823	30.1189	30.7835	30.3015
360121	1.3059	0.9246	31.6766	22.1967	32.9106	28.0639
360123	1.5042	0.9082	28.5435	30.0862	31.5149	30.0236
360125	1.2614	0.8555	27.1776	28.8237	28.0379	28.0071
360130	1.3605	0.9082	28.1811	28.5433	29.7395	28.7979
360131	1.4918	0.8650	27.3426	28.3618	28.7700	28.1660
360132	1.4508	0.9624	29.8411	29.5751	31.5629	30.3076
360133	1.7092	0.9624	33.1812	33.9534	34.8154	33.9938
360134	1.7893	0.9624	29.9198	31.9438	32.3503	31.4241
360137	1.8571	0.9082	30.3116	32.2727	33.2378	32.0143
360141	1.7533	0.8628	31.9397	32.0733	32.7782	32.2474
360143	1.4331	0.9082	28.0693	27.0053	28.0817	27.7280
360144	1.4492	0.9082	29.6547	29.5081	31.0418	30.0723
360145	1.5767	0.9082	29.3271	29.8688	30.7653	29.9946
360147	1.4745	0.8555	29.2371	28.0794	29.5821	28.9716
360148	1.2665	0.8555	25.7460	28.4538	29.4819	27.8748
360150	1.4450	0.9082	27.8840	27.8860	28.7383	28.1724
360151	1.3858	0.8650	26.9672	28.3917	29.2479	28.3557
360152	1.6437	1.0163	33.1017	35.3636	38.6208	35.6295
360153	1.0408	0.8555	21.8416	22.3028	22.2992	22.1453
360155	1.5129	0.9082	29.1711	30.0263	31.6318	30.2212
360156	1.2161	0.8674	26.2268	27.4185	28.7732	27.4930
360159	1.5048	1.0025	29.0187	29.1683	31.7186	29.9873
360161	1.4352	0.8639	27.7423	29.4713	29.7974	29.0175
360163	1.8520	0.9624	31.2087	31.1214	35.9313	32.7672
360170	1.3566	1.0163	30.0688	30.9891	30.4758	30.5174
360172	1.4106	0.9082	30.2330	31.2620	33.1946	31.5024
360174	1.4016	0.9172	28.3769	29.2419	29.6556	29.0991

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360175	1.3096	1.0025	29.7499	31.8340	31.7026	31.1036
360179	1.6158	0.9624	31.3540	30.6820	31.6922	31.2533
360180	2.5220	0.9082	32.0225	30.3025	32.9705	31.8017
360185	1.4175	0.8555	26.4210	27.4008	27.6522	27.1534
360187	***	*	27.3745	28.2630	31.4188	28.8678
360189	1.1225	1.0163	28.3738	28.8931	29.4708	28.9364
360192	1.4530	0.9082	29.1999	31.7957	32.2091	31.1258
360195	1.1421	0.9082	27.2630	28.4907	29.0980	28.3002
360197	1.3514	0.8555	28.5267	30.3316	31.0116	29.9915
360203	1.1956	0.8555	27.7569	28.7975	29.7199	28.7550
360210	1.4152	1.0163	31.8182	35.1678	37.5771	34.9693
360211	1.6242	0.8555	27.5081	26.9504	26.8677	27.1117
360212	1.4042	0.9082	28.5882	28.8865	31.1956	29.5446
360218	1.3838	1.0163	31.1641	31.4458	31.3310	31.3170
360230	1.5862	0.9082	30.5995	29.9181	31.6669	30.7266
360234	1.4362	0.9624	30.7926	29.5412	33.3664	31.1901
360236	1.4186	0.9624	29.9367	31.7585	32.1567	31.3134
360239	1.4331	0.9172	31.7938	32.3401	33.2718	32.5127
360241	***	*	25.8137	28.0304	29.5279	27.8946
360242	1.9199	*	*	*	*	*
360245	0.8463	0.9082	20.4589	20.8560	21.7637	21.1049
360247	0.6198	1.0163	*	*	20.0037	20.0037
360253	***	*	34.6887	33.3121	37.3905	35.0706
360259	1.3694	0.9374	28.0886	29.3681	31.0669	29.4823
360261	1.2686	0.8909	26.6262	28.2317	32.7931	29.2218
360262	1.3275	0.9374	31.5637	33.1908	34.1099	32.9417
360263	1.9512	0.9254	28.1671	25.5127	26.8628	26.7667
360266	2.2686	1.0163	29.8385	31.3706	33.4559	31.8486
360269	1.9619	0.9624	25.5191	26.3965	34.8464	29.0819
360270	1.1560	0.8555	28.8677	30.0580	32.1049	30.6384
360271	1.4738	0.9624	28.4353	30.8070	32.9727	30.7694
360272	***	*	38.1014	*	*	38.1014
360273	***	*	37.6645	*	*	37.6645
360274	1.6329	0.9172	*	*	41.5894	41.5894
360275	***	*	*	*	35.3416	35.3416
360276	1.3571	0.8628	*	*	30.8602	30.8602
360347	1.2052	1.0163	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360348	1.6182	1.0163	*	*	*	*
360349	1.4026	0.9374	*	*	*	*
360350	1.8062	0.9624	*	*	*	*
360351	1.9867	0.8850	*	*	*	*
360352	1.0842	0.8628	*	*	*	*
360354	1.4011	0.9624	*	*	*	*
360355	1.5439	0.9183	*	*	*	*
370001	1.6993	0.8903	28.4907	27.2881	29.2907	28.3843
370002	1.2418	0.8052	26.2486	26.5804	28.5178	27.1335
370004	1.1751	0.8446	28.2804	27.2378	29.4714	28.3160
370006	1.2115	0.8798	25.2307	27.5299	28.6399	27.1064
370007	0.9619	0.8052	21.1260	25.7680	29.2831	25.4572
370008	1.4129	0.8900	27.9944	29.1467	29.2458	28.8413
370011	0.9562	0.8900	23.1761	24.5886	26.7301	24.8297
370013	1.4968	0.8900	28.3502	29.7899	32.8050	30.3615
370014	1.2150	0.8445	28.8962	29.3407	28.8058	29.0123
370015	0.9979	0.8798	27.8061	27.6086	27.9015	27.7724
370016	1.5857	0.8900	30.4672	29.6737	30.9822	30.3796
370018	1.5379	0.8798	31.2335	29.3285	29.9348	30.1154
370019	1.1741	0.8052	26.7613	30.4599	30.9046	29.3782
370020	1.5729	0.8900	24.7520	24.7484	26.5784	25.3619
370022	1.3858	0.8306	26.4836	24.4735	26.1508	25.6663
370023	1.3323	0.8142	24.9580	27.4272	27.9018	26.8583
370025	1.3829	0.8798	24.8336	27.0211	27.6951	26.4528
370026	1.4507	0.8900	26.0203	26.8057	28.1146	26.9937
370028	2.0270	0.8900	29.9849	31.9029	33.9521	31.9991
370029	1.1511	0.8052	30.0134	30.3712	31.0013	30.4602
370030	0.9910	0.8798	26.0831	26.5853	27.9552	26.8681
370032	1.4856	0.8900	28.0739	30.2497	29.6486	29.2901
370034	1.2867	0.8052	23.2192	23.9679	29.5364	25.5443
370036	1.0370	0.8052	21.1544	22.1686	21.3785	21.5609
370037	1.8563	0.8900	26.8992	28.9215	30.8721	28.8559
370039	1.1530	0.8903	25.3422	26.7579	27.7301	26.6250
370040	0.9917	0.8052	19.7644	21.6739	23.4331	21.6824
370041	0.8609	0.8903	29.5074	26.4346	25.4871	27.1154
370047	1.4945	0.8900	27.8937	29.6739	32.3165	30.0356
370048	0.9653	0.8052	23.4848	24.2668	24.1343	23.9599

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
370049	1.4371	0.8052	24.2099	22.8526	28.2783	25.0600
370051	1.0771	0.8052	21.8716	22.8411	25.2437	23.3375
370054	1.2593	0.8052	23.4644	25.4821	31.2786	26.7359
370056	1.7795	0.8616	27.6178	26.9562	31.0225	28.6018
370057	0.9892	0.8903	23.1814	21.0790	21.6866	21.9676
370060	***	*	25.5571	29.0333	*	27.1132
370065	1.0374	0.8148	24.0062	23.7889	27.6147	25.2679
370072	0.7840	0.8310	22.8598	17.3061	22.6081	20.6800
370078	1.6690	0.8903	30.4837	28.7496	30.0395	29.7756
370080	0.9537	0.8052	23.7231	22.4258	20.5624	22.2160
370083	0.8441	0.8103	21.9162	21.3677	19.0707	20.7313
370084	1.0783	0.8052	17.4202	17.7119	16.9006	17.3311
370089	1.5651	0.8052	22.0607	23.8318	25.9159	24.0554
370091	1.7197	0.8903	28.0487	28.3945	29.9801	28.8357
370093	1.9314	0.8900	26.7272	29.0161	30.3405	28.6784
370094	1.4661	0.8900	28.3512	29.5931	29.7407	29.2592
370097	1.3617	0.8616	28.0911	28.1234	28.0485	28.0899
370099	1.0863	0.8900	30.5437	28.8908	29.8196	29.7121
370100	0.8879	0.8152	20.6298	18.2493	20.4983	19.7870
370103	1.0503	0.8052	22.2675	23.4746	23.9559	23.2347
370105	2.1142	0.8900	30.5438	30.9068	36.1174	32.0645
370106	1.5245	0.8900	29.6797	31.4433	32.4747	31.2193
370112	1.0149	0.8052	19.0130	20.2239	20.4699	19.9447
370113	1.1529	0.8646	30.0061	28.3511	28.2888	28.8884
370114	1.7327	0.8903	27.1348	32.9928	34.7611	31.4511
370138	1.0298	0.8052	23.6348	24.7631	28.4293	25.7195
370139	0.9194	0.8052	21.0759	19.3691	22.7663	21.0194
370148	1.5057	0.8900	29.3447	30.8781	32.6383	30.9688
370149	1.3740	0.8354	23.0764	25.0025	27.3475	25.0933
370153	1.0947	0.8052	25.9238	30.0891	28.8427	28.2741
370156	1.0078	0.8173	22.7140	22.3940	23.9498	23.0193
370158	0.9116	0.8900	22.0056	22.2823	23.6271	22.6383
370166	0.9198	0.8903	26.3420	22.9735	24.2071	24.5055
370169	0.7920	0.8215	24.5389	20.5348	20.0430	21.8109
370170	0.9052	1.4444	*	*	*	*
370171	1.0000	1.4444	*	*	*	*
370172	0.8044	1.4702	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
370173	1.0007	1.4444	*	*	*	*
370176	***	*	26.6687	27.2899	*	26.9843
370178	0.9180	0.8052	15.6720	17.3536	21.1275	17.9568
370180	1.2523	1.4444	*	*	*	*
370183	0.9346	0.8903	30.3850	25.4218	25.6096	27.0506
370190	1.6477	0.8903	32.5635	35.6046	42.6067	37.1583
370192	1.9251	0.8900	19.1346	28.9574	32.6197	27.3274
370196	***	*	24.6984	*	*	24.6984
370199	0.9552	0.8900	23.9376	25.9775	26.7845	25.6708
370200	***	*	19.7060	27.9940	35.8719	26.8170
370201	1.5046	0.8900	25.5882	30.4213	30.9026	28.9180
370202	1.4666	0.8903	25.8261	29.3845	30.9936	28.8532
370203	1.8920	0.8900	30.3641	31.6266	32.1871	31.6717
370206	1.9178	0.8900	30.8151	28.9491	30.0585	29.9057
370210	1.9062	0.8903	25.7905	29.4082	29.9079	28.4566
370211	1.1934	0.8900	30.9656	32.7888	34.6101	32.9440
370212	1.9722	0.8900	20.0919	23.4166	27.1375	23.5295
370214	0.8377	0.8173	20.1495	22.3796	25.0447	22.5261
370215	2.2825	0.8900	32.0950	32.7257	33.2373	32.7263
370216	2.1658	0.8903	29.6658	29.1189	26.1707	28.1248
370218	1.4156	0.8903	23.7517	29.6378	28.7572	27.2714
370219	***	*	41.4392	*	*	41.4392
370220	2.2137	0.8900	21.3168	22.2077	20.9298	21.4203
370222	1.9360	0.8900	26.9175	28.6123	28.3453	27.9656
370223	***	*	24.0154	*	19.6604	21.4670
370224	***	*	*	21.5542	*	21.5542
370225	1.1413	0.8900	*	*	*	*
370226	***	*	*	*	37.1390	37.1390
370227	1.0250	0.8903	*	*	25.9830	25.9830
370228	1.1823	0.8903	*	*	29.2557	29.2557
370229	1.0257	0.8052	*	*	*	*
370231	0.9969	0.8903	*	*	*	*
370232	1.1109	0.8052	*	*	*	*
380001	1.2530	1.1221	33.8490	36.3316	37.7584	36.0275
380002	1.3507	1.0089	32.6830	32.7006	33.7907	33.0702
380004	1.6902	1.1221	36.1021	37.7310	38.7848	37.5392
380005	1.4128	1.0089	33.5765	33.5424	36.4765	34.5241

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
380007	1.9680	1.1221	36.4222	37.9358	39.2842	37.8818
380009	2.1862	1.1221	36.5688	36.8442	39.1393	37.5615
380014	1.9778	1.0340	35.7101	36.4373	36.1111	36.0952
380017	1.7902	1.1221	36.8103	37.5098	38.6492	37.6722
380018	2.0193	1.0089	32.4884	32.3945	33.4301	32.7883
380020	1.4677	1.1331	35.7392	37.4343	42.4903	38.6506
380021	1.5246	1.1221	33.0628	33.3855	35.2942	33.9333
380022	1.4159	1.0149	30.9181	32.6138	34.0849	32.6081
380025	1.2343	1.1221	38.1507	38.7401	40.2542	39.0981
380027	1.4336	1.1032	31.4398	33.7027	35.3681	33.5331
380029	1.3160	1.1119	33.3368	34.4907	36.3780	34.8151
380033	1.1325	1.1331	36.0798	36.6589	38.9026	37.2572
380037	1.4089	1.1221	34.0321	36.0715	37.8397	36.1223
380038	1.3228	1.1221	35.0350	36.3586	37.3367	36.2465
380040	1.5283	1.0089	34.4500	37.3200	39.0280	37.0491
380047	1.8942	1.1032	35.8165	37.9901	39.2864	37.8086
380050	1.4662	1.0089	31.3088	32.4377	35.5034	33.1746
380051	1.8579	1.1221	35.0114	37.3363	39.5771	37.3333
380052	1.2455	1.0089	27.7656	29.1449	30.5763	29.1627
380056	1.2401	1.1119	31.0210	31.9034	32.2946	31.7201
380060	1.5979	1.1221	35.1106	36.9581	37.6168	36.6196
380061	1.6961	1.1221	35.8922	37.9554	39.8524	37.8861
380071	1.5130	1.1221	31.6821	32.7466	36.1630	33.5296
380075	1.4781	1.0089	34.0197	36.0119	37.8963	35.9417
380082	1.3415	1.1221	37.7268	38.8914	40.5892	39.0683
380089	1.3650	1.1221	37.0017	37.7878	39.3331	38.0936
380090	1.3301	1.1032	41.4540	41.3541	36.1957	39.4825
380091	1.6124	1.1221	39.7431	47.7003	43.5979	43.8371
380100	***	*	45.3882	*	*	45.3882
380102	1.8467	1.1331	*	*	*	*
390001	1.5928	0.8521	25.4188	27.9772	27.1369	26.8091
390002	1.4560	0.8579	25.9827	26.9670	28.0217	26.9883
390003	1.1897	0.8521	26.2872	26.6558	28.5550	27.1598
390004	1.7151	0.9172	26.5054	29.3249	30.1116	28.6336
390006	1.9048	0.9172	30.9914	32.8108	34.0319	32.6975
390008	1.1052	0.8581	22.9417	25.0200	23.3722	23.7761
390009	1.7909	0.8521	29.0286	29.4416	29.4788	29.3179

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390010	***	*	26.0966	27.8944	*	26.9767
390012	1.2900	1.0780	34.2004	35.6251	36.5075	35.4492
390013	1.4998	0.9172	28.3039	26.8792	28.6128	27.9375
390016	1.3710	0.8521	26.1802	25.6660	28.0791	26.6336
390019	1.2656	0.9418	25.3185	25.2047	27.4886	25.9672
390023	1.2198	1.0780	36.2618	37.9254	40.0307	38.0623
390024	***	*	37.4815	*	*	37.4815
390025	0.5715	1.0780	*	*	*	*
390026	1.2953	1.0780	36.0608	36.6927	37.8982	36.8748
390027	1.8176	1.0780	40.9110	42.5592	43.2863	42.2614
390028	1.7616	0.8579	29.6218	31.3868	29.7659	30.2416
390030	1.1774	0.8856	26.5678	26.9684	29.2589	27.6203
390031	1.2218	0.8856	26.1258	27.5747	30.8796	28.1344
390032	1.3312	0.8579	25.3756	27.3294	28.0123	26.9158
390035	1.2342	1.0780	27.2130	27.6331	30.9600	28.6617
390036	1.5866	0.8579	26.1956	30.1286	32.9773	29.7227
390037	1.4602	0.8579	27.0788	31.6832	31.5443	30.0435
390039	1.3655	0.8558	22.1531	23.3456	24.9694	23.4740
390041	1.2656	0.8579	25.1190	26.4415	26.5753	26.0714
390042	1.5148	0.8579	29.6213	30.6691	30.9971	30.4337
390043	1.2296	0.8521	24.3590	26.4451	27.6266	26.1527
390044	1.6128	0.9047	29.9959	30.6946	30.4850	30.4001
390045	1.4760	0.8521	25.8800	26.4450	25.4029	25.8954
390046	1.8301	0.9760	32.5273	32.1156	34.3559	33.0452
390048	1.1692	0.9172	28.4563	29.0278	30.0870	29.1884
390049	1.5518	0.9418	31.0290	32.7809	33.9546	32.6141
390050	2.1229	0.8579	29.6715	32.0935	32.6719	31.5014
390052	1.1984	0.8568	26.3700	27.4028	28.0662	27.3003
390054	***	*	27.5696	*	*	27.5696
390056	1.1238	0.8557	24.7038	25.5903	26.0944	25.4676
390057	1.3731	1.0780	31.0279	33.9576	34.1227	33.0166
390058	1.4268	0.9172	29.6620	29.4647	31.4346	30.2160
390061	1.5125	0.9760	30.9208	30.2319	33.2839	31.3678
390062	1.1590	0.8529	22.8856	37.2849	24.7403	28.3031
390063	1.9432	0.8521	28.3987	30.3687	29.6085	29.4599
390065	1.3869	1.0539	31.8841	31.2628	34.1509	32.4868
390066	1.4935	0.9172	29.0033	28.3747	28.4545	28.6018

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390067	1.8047	0.9760	32.2891	30.5601	32.7009	31.8523
390068	1.2866	0.9760	29.6984	28.2183	31.3686	29.7350
390070	1.3814	1.0780	34.5501	33.4969	34.5022	34.1840
390071	1.0479	0.8521	26.3830	27.8695	29.4067	27.8637
390072	1.0365	0.8521	28.8145	28.0714	29.3008	28.7479
390073	1.7549	0.8529	27.0876	28.8519	30.4073	28.7640
390076	1.3590	1.0780	33.9908	34.0355	36.0337	34.6436
390079	1.8713	0.8762	26.0199	26.9676	29.0245	27.3480
390080	1.4522	1.0780	31.6210	33.0003	34.7963	33.0758
390081	1.3314	1.0780	36.4788	37.7643	37.7381	37.3396
390084	1.2793	0.8521	24.3191	24.8010	26.7795	25.2800
390086	1.5945	0.8521	24.7454	25.3096	25.8212	25.3007
390090	1.8764	0.8579	30.1256	31.9282	33.7323	31.8674
390091	1.2620	0.8521	23.2118	23.9434	24.9895	24.0598
390093	1.2290	0.8521	23.8846	23.5291	23.4916	23.6341
390095	1.2005	0.8521	25.3859	25.9594	25.8271	25.7150
390096	1.6264	0.9047	30.3910	31.7443	32.9599	31.7312
390097	1.2966	1.0780	28.1285	30.4946	31.2933	29.9565
390100	1.6541	0.9760	32.7836	32.8949	33.8098	33.1901
390101	1.3191	0.9539	25.9850	28.6622	30.5652	28.4498
390102	1.4762	0.8579	25.5336	26.3716	27.4078	26.4615
390104	1.0256	0.8521	20.4552	26.8407	25.5500	24.5842
390107	1.7718	0.8579	25.6790	26.6305	27.5113	26.6481
390108	1.3264	1.0780	34.3066	33.3017	33.0812	33.5657
390110	1.6616	0.8521	25.7159	28.5314	29.2114	27.8372
390111	2.3297	1.0780	37.7322	34.5571	37.4034	36.5385
390112	1.1114	0.8558	18.4185	19.5361	21.7618	19.8898
390113	1.3636	0.8521	24.8669	25.9952	27.3239	26.1026
390114	1.5335	0.8579	28.5336	28.2039	31.1727	29.3417
390115	1.4010	1.0780	32.5058	32.8427	32.4906	32.6138
390116	1.4090	1.0780	33.9295	34.5119	35.8124	34.7722
390117	1.2284	0.8523	22.2327	26.0642	29.4532	25.9021
390118	1.2756	0.8521	23.6535	23.7128	24.9150	24.0866
390119	1.3599	0.8521	25.3907	25.9784	27.7668	26.4246
390122	1.0543	0.8574	24.6434	24.0424	25.6753	24.7750
390123	1.2379	1.0780	35.1244	34.1121	36.2907	35.1769
390125	1.2563	0.8543	24.0199	24.4654	28.2329	25.5409

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390127	1.5706	1.0780	33.1227	34.6488	37.2911	35.0077
390128	1.2760	0.8579	25.1858	26.0441	26.6048	25.9610
390130	1.2073	0.8521	30.7083	26.7324	27.8831	28.3944
390131	1.4113	0.8579	27.7146	26.9190	27.7765	27.4675
390132	1.6245	1.0780	30.0751	33.1853	34.6686	32.6204
390133	1.8571	1.0663	33.0604	35.0046	33.5858	33.8932
390137	1.5065	0.8521	26.9156	27.9033	28.8768	27.9121
390138	1.3244	0.9172	27.7565	29.0224	31.9340	29.6092
390139	1.3858	1.0780	36.5001	36.8337	38.9715	37.4666
390142	1.5812	1.0780	33.3509	38.1793	41.7965	37.8882
390145	1.4739	0.8579	26.9212	27.6510	28.4472	27.7026
390146	1.1970	0.8543	23.9878	27.5267	28.5944	26.6700
390147	1.4098	0.8579	29.0995	30.4797	29.9003	29.8258
390150	1.1325	0.8552	22.6483	27.2922	29.5097	26.6124
390151	1.4533	1.0539	31.8967	35.0627	36.1838	34.4568
390153	1.3662	1.0780	36.0287	37.0995	38.6509	37.2968
390154	1.2217	0.8521	23.9785	24.6857	26.5297	25.0858
390156	1.3617	1.0780	33.7057	34.9903	37.3076	35.3187
390157	1.2496	0.8579	23.0989	23.7167	25.3304	24.0528
390160	1.4641	0.8579	25.2043	27.5196	28.6869	27.1706
390162	1.5709	1.1296	35.1844	36.7008	37.4703	36.4185
390163	1.3306	0.8579	24.8761	25.4594	26.9809	25.7955
390164	2.2789	0.8579	29.7778	29.0556	30.3482	29.7279
390166	***	*	28.2178	*	*	28.2178
390168	1.6857	0.8579	27.3674	28.2578	30.9235	28.8822
390169	1.1762	0.8521	26.6063	28.4619	28.7411	27.9870
390173	1.3215	0.8558	27.6039	28.0999	29.4695	28.4211
390174	1.8138	1.0780	35.1118	36.5352	38.5670	36.7628
390176	1.0420	0.8579	*	27.5270	32.1051	29.5889
390178	1.4445	0.8612	23.9166	25.2325	26.0853	25.0756
390179	1.4701	1.0780	31.5498	33.9916	35.7591	33.8296
390180	1.4303	1.0780	38.2997	37.8677	39.2901	38.4851
390181	***	*	27.8833	*	*	27.8833
390183	1.1887	0.8521	28.2211	28.8361	29.9287	29.0390
390184	1.0458	0.8579	23.9973	24.1461	24.6116	24.2542
390185	1.3942	0.9418	25.5318	28.1346	29.5155	27.8683
390189	1.0954	0.8521	23.4902	25.3686	26.8189	25.2753

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390192	1.0196	0.8521	23.7958	24.7427	25.0085	24.5203
390194	1.2336	0.9418	23.7367	27.8231	27.5260	26.2940
390195	1.6061	1.0780	37.2504	36.8626	39.5226	37.8846
390196	1.5301	*	*	*	*	*
390197	1.3716	0.9418	27.7303	28.1999	28.4855	28.1347
390198	1.0016	0.8521	21.0861	21.3574	23.6249	22.0336
390199	1.1525	0.8521	24.5469	24.9642	25.6275	25.0628
390201	1.5511	0.9691	28.5668	28.7755	33.2321	30.2676
390203	1.5230	1.0780	30.7244	33.0056	39.2667	34.4792
390204	1.3951	1.0780	32.0242	33.8120	31.6920	32.4668
390211	1.4122	0.8612	27.7875	28.0796	29.5567	28.4769
390217	1.2688	0.8579	26.2706	25.6917	27.0886	26.3518
390219	1.3817	0.8579	26.3263	27.2812	28.9463	27.5217
390220	1.2574	1.0780	32.0891	33.0323	34.0933	33.0447
390222	1.4380	1.0780	32.7077	34.5835	35.0162	34.1313
390223	2.1413	1.0780	36.5784	35.8030	36.4686	36.2827
390225	1.3671	0.9760	26.3642	*	37.2003	31.3972
390226	1.7682	1.0780	35.4683	35.5564	37.7252	36.2815
390228	1.5300	0.8579	25.5120	28.4321	28.7341	27.5570
390231	1.4535	1.0780	35.2312	35.0675	35.2479	35.1832
390233	1.4332	0.8521	28.3660	29.5938	31.2920	29.7908
390236	1.0294	0.8524	24.5574	25.1866	26.6442	25.4333
390237	1.6878	0.8521	29.9748	29.6917	29.3123	29.6520
390256	1.9907	0.9172	28.5887	31.6455	32.5650	30.9753
390258	1.4564	1.0780	32.0551	33.7330	37.1156	34.3523
390263	1.6615	0.9418	30.2069	31.1718	31.3913	30.9524
390265	1.6237	0.8579	27.7795	27.8241	30.8343	28.8119
390266	1.1383	0.8612	23.0142	23.5248	24.2255	23.5948
390267	1.5021	0.8579	25.7571	28.4250	30.7224	28.2795
390268	1.4705	0.8640	28.4200	30.0652	30.2637	29.6045
390270	1.7441	0.8521	27.0301	29.3622	31.2862	29.3404
390272	0.6330	1.0780	32.9918	29.4836	28.9815	30.3399
390278	0.7864	1.0780	28.8318	33.9596	32.6176	31.7776
390285	***	*	38.4703	43.0793	42.6411	41.2248
390286	***	*	31.7337	32.6998	34.3467	32.9330
390290	1.8432	1.0780	47.7663	41.9121	45.5855	45.0203
390304	1.4348	1.0780	33.4134	35.0741	31.4118	33.2717

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390307	1.9281	0.8612	22.9474	27.2053	28.6025	26.1219
390311	***	*	49.9027	*	*	49.9027
390312	1.4452	1.0780	51.3372	42.3481	47.4912	46.6973
390313	1.1402	0.8856	*	27.3018	28.2730	27.7674
390314	1.9104	0.9418	*	*	31.2627	31.2627
390315	***	*	*	*	33.7886	33.7886
390316	2.1098	0.9047	*	*	27.5474	27.5474
390317	0.8038	1.0780	*	*	40.0462	40.0462
390318	1.4192	0.9418	*	*	28.8744	28.8744
390319	0.9481	0.8579	*	*	*	*
390320	2.7965	1.0780	*	*	*	*
390321	1.7804	0.9418	*	*	*	*
400001	1.3274	0.4302	15.4249	15.9192	16.7467	16.0408
400002	***	*	12.9793	14.2946	*	13.6163
400003	1.4027	0.4278	14.6859	15.8816	16.1022	15.5378
400004	1.1337	0.4302	13.5197	14.5542	15.6128	14.5649
400005	1.1494	0.4302	11.7590	12.6516	13.5902	12.6912
400006	1.2753	0.4302	*	*	11.3150	11.3150
400007	1.3194	0.4302	10.4934	10.7767	12.4403	11.1611
400009	1.0496	0.3577	10.1212	14.0016	12.1371	11.8594
400010	0.8029	0.3384	10.4206	12.8584	9.9686	10.7816
400011	1.2081	0.4302	9.4068	10.7620	11.2889	10.4922
400012	1.6634	0.4302	*	11.1553	12.3642	11.7247
400013	1.3877	0.4302	12.3073	12.7900	13.8665	13.0128
400014	1.4610	0.3612	12.3301	11.0722	11.8099	11.7048
400015	1.2566	0.4302	21.9225	17.6943	20.6014	19.9015
400016	1.5854	0.4302	17.9107	19.1577	18.3119	18.4599
400017	***	*	10.0590	*	*	10.0590
400018	1.3636	0.4302	13.1572	13.6091	14.0267	13.6205
400019	1.5566	0.4302	15.2364	15.0604	15.9353	15.3872
400021	1.5607	0.4570	14.9779	16.3677	16.9832	16.1033
400022	1.4793	0.4278	15.2124	15.3660	16.3760	15.6441
400024	0.7732	0.3612	13.7215	14.2708	12.9549	13.5783
400026	1.2407	0.3577	8.9064	9.8155	10.7169	9.7988
400028	***	*	9.6941	11.1923	10.2934	10.3638
400032	1.1343	0.4302	10.7844	11.9013	12.2669	11.6859
400044	1.7300	0.4278	12.1393	13.4579	14.6579	13.6085

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
400048	1.2979	0.3577	10.5176	11.5766	13.1850	11.7959
400061	2.1704	0.4302	17.4504	18.5327	20.5087	18.8372
400079	1.5588	0.3384	10.6127	11.3550	11.9824	11.3404
400087	1.2640	0.4302	12.0034	12.6233	13.4288	12.6871
400098	1.2431	0.4302	12.8756	13.2365	13.3671	13.1717
400102	1.2316	0.4302	12.1257	12.6314	10.9542	11.7721
400103	2.0761	0.3612	11.3314	12.7285	11.9853	12.0090
400104	1.3358	0.4302	12.6934	12.9616	11.8195	12.5011
400105	1.0711	0.4302	17.0463	25.3823	19.6129	19.9057
400106	1.1191	0.4302	14.8544	14.1766	15.1456	14.7145
400109	1.4847	0.4302	14.5713	15.4910	16.2304	15.4433
400110	1.2368	0.3544	10.8214	11.2311	12.3738	11.4462
400111	1.2060	0.3384	10.7892	11.0467	12.0683	11.3123
400112	1.2379	0.4302	11.2303	9.6181	13.0534	11.1342
400113	1.3390	0.4278	11.5948	11.9672	12.8788	12.1619
400114	1.2113	0.4302	11.6872	11.5514	12.7842	12.0298
400115	1.0598	0.4302	10.6809	12.0201	10.9564	11.2441
400117	1.0324	0.4302	12.1540	12.2159	13.0609	12.4850
400118	1.3323	0.4302	12.6199	13.3983	14.0618	13.3770
400120	1.4734	0.4302	14.5205	14.6591	15.3683	14.8571
400121	1.0669	0.4302	9.9713	11.7462	11.7441	11.2726
400122	2.2443	0.4302	10.0966	13.1851	13.6602	12.0852
400123	1.2369	0.3612	13.8601	13.4317	14.3030	13.8583
400124	2.8599	0.4302	19.1704	21.9082	22.0619	21.0750
400125	1.2425	0.3892	13.1078	12.7141	13.5864	13.1629
400126	1.2276	0.4570	*	14.2108	13.0372	13.5539
400127	2.2024	0.4302	*	12.0796	10.6621	11.1995
400128	1.0442	0.4302	*	23.6366	14.1088	17.2092
410001	1.3296	1.1613	30.5865	30.8038	33.6421	31.6567
410004	1.3994	1.1613	35.2384	33.7118	35.8403	34.9238
410005	1.2979	1.1613	34.2846	38.2842	38.0619	36.9368
410006	1.4558	1.0751	33.9961	35.4462	36.1985	35.2228
410007	1.7064	1.1613	34.4774	37.0287	38.3867	36.7006
410008	1.3757	1.0751	33.6384	34.6138	35.3809	34.5644
410009	1.3355	1.0751	34.3427	36.0892	36.4091	35.6362
410010	1.1199	1.1613	34.9330	38.4603	39.9638	37.7769
410011	1.4645	1.1613	36.7668	38.5007	37.6589	37.6665

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
410012	1.6248	1.1613	36.5207	37.5223	38.6851	37.5744
410013	1.2620	1.1412	39.8659	38.2253	38.6414	38.8940
420002	1.6629	0.9300	31.2247	32.3569	33.2952	32.2569
420004	2.1010	0.9295	30.0764	31.8610	34.1012	32.1498
420005	1.2940	0.8450	26.5044	28.0173	29.8412	28.1181
420006	2.1518	*	29.1404	31.5368	32.2965	30.9655
420007	1.7111	0.9128	28.9557	31.1080	31.3033	30.4861
420009	1.4017	0.9128	28.6648	29.1084	29.6808	29.1549
420010	1.1694	0.8478	26.5523	27.0435	27.8709	27.1665
420011	1.1720	0.9357	26.0585	25.9484	25.1689	25.7394
420015	1.3418	0.9357	27.4929	27.9759	29.5582	28.3316
420016	1.0027	0.8438	23.4323	23.2125	23.4618	23.3687
420018	1.9284	0.8799	29.0923	28.9660	30.2579	29.4553
420019	1.1621	0.8596	25.8119	23.7910	26.9977	25.5119
420020	1.3033	0.9295	29.2935	28.9093	30.9488	29.7089
420023	1.8241	0.9357	30.4492	31.2602	32.2488	31.4072
420026	1.9124	0.8799	29.5066	31.2504	32.5572	31.1347
420027	1.6300	0.9128	31.3797	30.6779	*	31.0258
420030	1.4921	0.9295	30.3424	31.3260	33.0987	31.5744
420033	1.3463	0.9357	32.4287	33.8157	33.5699	33.2702
420036	1.2688	0.8695	26.3480	27.1715	28.0250	27.1767
420037	1.4064	0.9357	32.7124	33.5291	34.1076	33.4635
420038	1.2847	0.9357	27.1524	29.5673	31.5388	29.4623
420039	1.0619	0.8970	26.3127	24.5270	26.0489	25.6075
420043	1.1861	0.8595	25.8366	24.2727	25.6018	25.2202
420048	1.3049	0.8799	27.4353	29.9094	30.5167	29.3111
420049	1.3260	0.8681	28.0920	28.4801	29.1163	28.5669
420051	1.8299	0.8478	27.6130	28.0711	29.6261	28.4477
420053	1.2963	0.8473	25.4820	26.4997	27.1081	26.3512
420054	1.1210	0.8446	26.7900	27.1580	28.2725	27.4120
420055	1.1416	0.8467	25.3144	25.9899	26.0255	25.7592
420056	1.3094	0.8438	29.7774	27.8175	29.3188	28.9542
420057	1.2963	0.8478	27.7137	29.5662	29.8897	29.0709
420062	1.0833	0.8563	27.2263	28.3129	29.4726	28.3826
420064	1.5616	0.8681	25.0654	26.4352	28.3216	26.6452
420065	1.5441	0.9295	28.1896	28.2922	28.9626	28.4895
420066	0.9570	0.8478	20.5743	26.0307	27.0504	24.3154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
420067	1.4142	0.8858	27.7167	29.0379	29.2066	28.6526
420068	1.5378	0.9571	28.0316	28.1555	30.0666	28.7169
420069	1.2850	0.8438	24.4656	25.1993	25.9447	25.2155
420070	1.4122	0.8695	27.6431	28.4000	28.5579	28.2053
420071	1.5208	0.9128	28.1099	28.6098	30.2531	29.0105
420072	1.1647	0.8438	20.7716	24.4951	25.2077	23.5012
420073	1.4865	0.8799	28.2671	29.5999	30.4941	29.4818
420078	1.9867	0.9357	32.8731	34.3181	33.3691	33.5209
420079	1.5363	0.9295	30.5981	31.7686	32.4626	31.6252
420080	1.4096	0.8858	32.8712	33.8785	35.2949	34.0334
420082	1.5126	0.9571	34.8864	33.5290	33.6670	33.9910
420083	1.4791	0.9128	29.6587	29.2264	33.5329	30.7160
420085	1.5196	0.9265	29.9085	31.3391	32.5361	31.2837
420086	1.5308	0.8799	29.6349	30.1406	30.5884	30.1347
420087	1.8321	0.9295	28.4632	28.8860	29.6136	29.0043
420089	1.6898	0.9295	31.7367	33.0906	35.2407	33.3707
420091	1.5567	0.8478	27.9062	28.0471	30.7482	28.8706
420098	1.1976	0.8462	27.6722	28.2058	29.6500	28.5992
420100	***	*	29.2979	*	*	29.2979
420101	1.0052	0.8858	33.1995	33.5957	33.0451	33.2696
420102	1.8906	0.9357	*	*	34.3207	34.3207
420103	1.2387	0.9357	*	*	*	*
430005	1.4208	0.8435	25.4385	27.1759	29.2386	27.2448
430008	1.1323	0.8970	27.2275	27.2961	28.1278	27.5654
430012	1.3663	0.9388	27.0195	28.5808	28.9595	28.1941
430013	1.2067	0.8435	28.4962	28.3679	29.7388	28.8759
430014	1.5187	0.8435	28.9295	29.2921	30.3630	29.5359
430015	1.3611	0.8435	28.0414	28.0093	28.9296	28.3270
430016	1.6144	0.9388	31.1336	31.5894	34.2610	32.4635
430027	1.7295	0.9388	29.2617	29.2432	31.1835	29.9366
430048	1.2480	0.8564	25.6428	26.9537	28.6697	27.1026
430060	0.9026	0.8435	*	11.7801	*	11.7801
430064	0.9703	*	17.7334	*	*	17.7334
430077	1.7929	1.0990	31.1945	35.3480	39.6547	35.4000
430081	1.0199	1.4448	*	*	*	*
430082	0.7513	1.4448	*	*	*	*
430083	1.0550	1.4448	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
430084	0.8832	1.4448	*	*	*	*
430089	2.2827	0.8968	24.9060	28.3217	28.7338	27.4480
430090	2.0301	0.9388	32.7395	33.8350	34.0212	33.5658
430091	2.0885	1.0990	26.7258	28.3496	29.0916	28.0819
430092	2.0494	0.8435	23.2527	26.6750	28.3015	26.0017
430093	0.9808	1.0990	24.7426	30.7398	30.2337	28.4605
430094	1.7420	0.8564	23.6624	23.9005	24.9804	24.2133
430095	2.3107	0.9388	32.5881	31.8141	38.2085	34.0836
430096	2.3728	0.8435	24.9623	28.0608	28.3796	27.0773
440001	1.1423	0.7919	25.4855	23.9380	25.8019	25.0735
440002	1.7402	0.8907	26.9133	28.4828	28.7976	28.0851
440003	1.3257	0.9246	26.0115	31.4162	31.1666	29.3051
440006	1.6645	0.9246	31.7394	32.6924	33.2995	32.6609
440007	1.1248	0.8138	22.7571	23.4825	23.6870	23.3271
440008	1.0281	0.8368	26.8857	26.2003	28.2870	27.1392
440009	1.1708	0.7919	24.4423	25.1184	26.0040	25.1835
440010	0.9243	0.7919	20.2497	23.8087	24.9022	22.8411
440011	1.4425	0.7919	24.8300	25.7912	27.1600	25.9502
440012	1.5952	0.7919	24.9261	26.2076	26.5953	25.9396
440015	1.9977	0.7919	27.1603	28.1389	28.4467	27.9223
440016	1.0765	0.8063	25.2512	25.4197	27.4924	26.0451
440017	1.8177	0.7919	26.1820	28.6110	27.1081	27.3237
440018	1.1740	0.7919	24.8568	26.0748	26.3363	25.7740
440019	***	*	26.2464	28.0387	30.1931	28.0787
440020	1.0657	0.7919	27.5626	28.0269	28.6636	28.0709
440024	***	*	26.2534	25.4398	*	25.8750
440025	1.2561	0.8407	24.0289	25.5605	26.7642	25.4762
440026	***	*	28.4615	26.5911	29.9514	28.3617
440029	1.4714	0.9246	31.4652	31.8872	32.1072	31.8356
440030	1.3554	0.7919	22.3144	23.1116	23.2575	22.8992
440031	1.2845	0.7938	22.0711	23.0937	24.1851	23.1142
440032	1.2903	0.7919	23.8030	25.4122	25.3202	24.8770
440033	1.1176	0.7946	23.9792	24.3197	24.4996	24.2751
440034	1.7491	0.7919	25.9138	26.7987	27.0736	26.5997
440035	1.3762	0.9246	27.9217	26.8725	27.7533	27.5134
440039	2.2785	0.9246	30.1918	32.4190	32.3384	31.6681
440040	0.8602	0.7919	21.1288	21.3795	23.0134	21.8153

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
440046	1.5007	0.9246	30.7334	31.5146	32.8764	31.6731
440047	0.9783	0.8257	25.2150	26.8032	28.6702	26.9106
440048	1.8888	0.9137	30.6725	31.5584	32.5404	31.5872
440049	1.7063	0.9137	29.8623	31.7148	32.6356	31.4058
440050	1.4510	0.7919	26.3825	27.1284	29.3303	27.5657
440051	0.9297	0.8001	23.6560	23.1773	24.8037	23.8861
440052	1.0648	*	24.4071	28.1868	*	26.2378
440053	1.3950	0.9246	30.3907	31.3189	32.4503	31.4080
440054	1.2435	0.7919	21.9641	25.7785	25.9377	24.4630
440056	1.2204	0.7919	24.0635	25.2050	25.9743	25.0917
440057	1.1740	0.7940	19.3546	25.1519	22.9222	22.2785
440058	1.1492	0.8582	29.1184	28.5093	28.0299	28.5506
440059	1.5321	0.9246	29.4532	30.4489	30.5995	30.1903
440060	1.3363	0.8257	26.5867	26.5518	27.3024	26.8209
440061	1.1152	0.7919	25.4134	25.9969	26.5212	25.9931
440063	1.7344	0.7952	26.0763	25.4344	24.7803	25.4192
440064	0.9734	0.8721	26.7957	26.9014	28.9331	27.5492
440065	1.4389	0.9246	25.6111	27.3501	27.6328	26.8707
440067	1.0879	0.7919	26.0866	26.5062	27.4606	26.6924
440068	1.1836	0.8531	27.9082	27.2646	28.3925	27.8565
440070	0.9667	0.8028	23.2228	24.4477	23.7568	23.8061
440072	1.1077	0.7919	26.1661	27.6990	29.4625	27.8065
440073	1.4586	0.9246	27.5133	28.3950	33.8232	29.7943
440081	1.3267	0.7971	21.9681	23.3000	24.5259	23.2799
440082	1.9820	0.9246	32.8941	34.4535	34.2270	33.8164
440083	0.9678	0.7919	25.7074	25.5397	31.8133	27.4028
440084	1.1913	0.7944	19.8950	21.3873	22.1562	21.1576
440091	1.8112	0.8721	28.9697	30.0650	31.3375	30.1465
440102	1.0781	0.7919	22.1114	23.5525	24.5121	23.3354
440104	2.0266	0.8721	28.0905	29.7326	30.2301	29.3691
440105	0.9050	0.7952	23.7154	24.6039	25.1558	24.4882
440109	1.0319	0.7989	22.5878	23.8465	25.0329	23.8752
440110	1.2059	0.7919	23.6275	23.8010	25.2412	24.2401
440111	1.3708	0.9246	29.7461	33.0828	34.8033	32.5048
440115	1.0246	0.8257	24.9778	25.2508	26.5072	25.5829
440120	1.5835	0.7919	26.0621	28.0271	29.3067	27.8170
440125	1.7354	0.7919	24.0934	24.7908	25.9494	24.9465

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
440130	1.1307	0.7919	26.3192	27.5525	29.7509	27.8864
440131	1.1097	0.9137	28.3162	29.0546	29.2776	28.8882
440132	1.2404	0.7919	29.3377	26.1823	26.0031	27.0744
440133	1.7764	0.9246	32.5726	33.2319	32.4641	32.7486
440135	***	*	27.2094	28.7658	*	27.7843
440137	1.1024	0.8657	24.6143	25.6931	26.9374	25.7242
440141	1.0666	0.7919	24.8737	24.3575	26.3678	25.1500
440144	1.2612	0.8531	26.3225	26.6282	28.1527	27.0256
440147	***	*	36.6978	33.5900	37.8346	36.1793
440148	1.2607	0.8215	28.0708	26.2483	26.9352	27.0789
440150	1.5299	0.9246	30.5513	32.9854	32.8334	32.1424
440151	1.2054	0.9246	28.6585	28.8412	29.7082	29.0660
440152	2.5625	0.9137	29.0588	28.7357	30.1779	29.3307
440153	1.0707	0.7919	23.3790	23.8797	25.5049	24.2283
440156	1.6720	0.8721	30.5161	31.0506	31.6017	31.0718
440159	1.4664	0.9137	27.2785	26.2728	29.3516	27.6174
440161	2.1078	0.9246	31.0667	32.2343	33.4813	32.2916
440162	***	*	24.6425	27.8605	32.8708	28.2006
440168	0.9044	0.9137	31.3316	37.0865	35.6076	34.6194
440173	1.5174	0.7919	23.1370	23.5486	24.5617	23.7711
440174	0.9085	0.8907	27.4579	27.4578	29.2147	28.0222
440175	1.0307	0.7919	26.7705	29.2713	28.1637	28.0598
440176	1.4968	0.7919	24.9420	26.1477	25.8830	25.6676
440180	1.1625	0.7946	24.3376	26.9310	28.0126	26.4469
440181	1.1717	0.8284	26.4763	26.2247	26.8006	26.5057
440182	0.9173	0.8063	24.9899	24.4173	26.1132	25.1673
440183	1.5613	0.9137	30.9923	31.9159	33.2870	32.0523
440184	1.1262	0.7952	26.9086	25.3287	23.3322	25.0223
440185	1.2332	0.8531	26.3974	25.6005	27.2121	26.4383
440186	0.9656	0.9246	28.2840	30.0775	29.4231	29.3781
440187	1.1201	0.7919	27.4034	27.2669	29.4492	28.0330
440189	1.3670	0.8310	30.5786	29.9065	32.4791	31.0665
440192	1.1026	0.9246	30.6533	32.0772	30.4030	31.0183
440193	1.4241	0.9246	25.9726	27.8132	29.2015	27.6576
440194	1.3855	0.9246	32.3020	32.1073	33.3464	32.6095
440197	1.5649	0.9246	31.4317	32.3241	33.1604	32.2961
440200	1.1684	0.9246	23.8288	23.3049	25.6800	24.2881

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440217	***	*	31.6650	33.8684	33.5264	33.0112
440218	2.3018	0.9246	36.9273	31.7847	34.8600	34.3070
440222	***	*	30.5148	32.4230	33.4779	32.1341
440225	0.8351	0.7919	26.9687	29.8273	31.2189	29.5476
440226	1.8051	0.7919	28.3199	28.4491	31.2423	29.3511
440227	1.4445	0.9246	31.9119	32.1862	33.3005	32.4840
440228	1.5313	0.9137	29.5372	31.2049	32.7230	31.2589
450002	1.5584	0.8594	29.7180	30.0562	31.6279	30.4327
450005	1.2589	0.8456	27.3473	27.9825	28.6433	28.0242
450007	1.2745	0.9071	24.4630	26.2568	27.9008	26.2410
450008	1.3007	0.8775	24.4372	26.1215	28.5492	26.3295
450010	1.6966	0.9929	30.1034	32.9053	35.9573	32.9324
450011	1.6446	0.9244	29.9302	30.9903	32.9877	31.3013
450015	1.7472	0.9734	30.3168	30.3228	30.4911	30.3779
450018	1.7997	0.9946	31.3131	32.9922	35.5712	33.2965
450021	2.0024	0.9734	31.7360	34.5462	35.7307	34.0291
450023	1.3908	0.8038	25.1683	25.6361	27.9984	26.2980
450024	1.7757	0.8594	27.3814	27.8816	27.1925	27.4827
450028	1.6425	0.9486	29.5689	29.8049	34.0997	31.2123
450029	1.5534	0.8312	28.6465	27.2662	28.3780	28.0928
450031	***	*	29.2141	28.8891	34.0104	30.5763
450032	1.3782	0.8593	26.3159	25.7989	24.7722	25.5859
450033	1.6415	0.9486	29.7668	31.6557	32.7706	31.4322
450034	1.5659	0.8456	29.6309	28.2761	30.5057	29.4205
450035	1.7041	0.9946	30.3369	30.8574	*	30.5883
450037	1.5611	0.8593	28.2622	26.8661	31.6332	28.8487
450039	1.6804	0.9584	29.8145	29.5097	31.1550	30.1911
450040	1.7943	0.8940	28.5469	30.0844	31.7878	30.1162
450042	1.7837	0.8648	27.6131	28.3649	29.9591	28.7245
450044	1.7955	0.9734	32.9921	36.3786	36.8350	35.4324
450046	1.6799	0.8576	27.2439	28.4297	29.1115	28.2783
450047	***	*	24.9670	24.6290	*	24.8091
450051	2.0476	0.9734	30.3976	31.0740	32.5581	31.3450
450052	1.1232	0.8018	24.3964	25.8142	26.8780	25.6896
450054	1.8685	0.8775	30.2211	30.7196	31.8152	30.9786
450055	0.9581	0.8018	24.1418	24.6436	24.1331	24.3059
450056	1.7335	0.9523	32.0902	33.7634	35.1758	33.7275

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450058	1.6760	0.9071	27.7318	27.8963	29.3038	28.3582
450059	***	*	28.5645	29.9336	30.4251	29.6617
450064	1.6215	0.9584	29.0495	30.6704	31.2918	30.3637
450068	2.2983	0.9946	32.0372	34.9179	36.0902	34.3951
450072	1.2590	0.9946	28.0921	28.7063	30.1911	29.0674
450073	0.8084	0.8018	22.2322	23.1471	27.3607	24.1130
450076	1.7389	*	*	*	*	*
450078	0.9125	0.8018	20.7800	21.0876	22.8792	21.5781
450079	1.5567	0.9734	36.8936	34.1533	35.0924	35.3302
450080	1.2802	0.9584	26.8111	28.6334	28.2834	27.9102
450082	1.2045	0.8018	25.5654	27.1314	28.0686	26.8222
450083	1.8349	0.8259	30.2054	28.6628	27.8743	28.9055
450085	1.1963	0.8018	26.3610	28.1669	28.9441	27.8191
450087	1.5252	0.9584	32.6556	34.2493	35.5922	34.2084
450090	1.3411	0.8668	22.7822	22.2148	21.7004	22.2188
450092	1.4103	0.8312	28.2278	28.3891	30.5314	29.0936
450097	1.5643	0.9946	31.9782	33.8910	34.3604	33.4331
450099	1.3224	0.8434	29.8491	25.5799	25.4382	26.8735
450101	1.6811	0.8648	28.4220	29.3777	30.4843	29.3988
450102	1.7949	0.8259	27.3364	27.5145	28.5283	27.8122
450104	1.2249	0.9071	27.7851	30.4631	31.5834	29.9121
450107	1.7114	0.8594	29.0328	29.6790	31.5472	30.1274
450108	1.1643	0.9071	22.4293	21.7619	23.4651	22.5508
450119	1.6775	0.8888	34.4161	31.0699	34.4231	33.3604
450123	1.0012	0.8456	24.0433	27.6445	25.6415	25.8683
450124	1.8454	0.9523	31.9797	32.9774	34.3913	33.0155
450126	***	*	32.0370	32.9729	33.9635	33.0184
450128	1.3469	0.8888	28.3171	28.9733	25.6071	27.5150
450130	1.2316	0.9071	26.9208	28.3786	29.5020	28.2589
450132	1.6455	0.9426	31.1361	34.8719	33.2761	33.1083
450133	1.6806	0.9554	30.9622	31.3911	33.3058	31.9181
450135	1.7157	0.9584	30.7909	30.8734	32.1719	31.2968
450137	1.6678	0.9584	35.7775	33.8235	36.3832	35.3104
450143	1.0086	0.9523	24.4346	25.1702	26.2306	25.2759
450144	0.8810	0.9554	31.1552	31.4041	33.9298	32.1350
450147	1.4830	0.8576	26.3032	27.3607	28.1864	27.2675
450148	1.3368	0.9584	30.0542	29.9522	32.0315	30.7189

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450151	***	*	22.8768	*	*	22.8768
450152	1.2507	0.8775	24.3442	25.7523	27.2981	25.8872
450154	1.3577	0.8018	24.2582	23.2210	26.8036	24.6426
450155	0.9518	0.8018	24.8773	25.2546	27.0261	25.7426
450162	1.1826	0.8940	33.7823	27.1453	27.1885	29.3979
450163	1.0821	0.8072	27.0967	27.6273	28.6735	27.8002
450165	1.1390	0.9071	30.2236	30.3796	31.6216	30.7510
450176	1.6011	0.8888	25.8587	28.4561	29.1369	27.9379
450177	1.1127	0.8018	26.0895	27.7791	28.5027	27.4708
450178	0.9348	0.9311	28.5990	27.5779	28.9534	28.3711
450184	1.7708	0.9946	30.9726	32.7090	34.0933	32.6058
450187	1.1680	0.9946	29.2749	29.3048	32.4972	30.4075
450188	0.9030	0.8018	24.6823	23.0844	23.5026	23.7701
450191	1.2449	0.9523	31.1339	30.0686	32.6122	31.2546
450192	1.0167	0.8289	26.9884	27.5539	29.0941	27.8974
450193	2.2410	0.9946	37.1906	38.2891	38.8688	38.1249
450194	1.2453	0.8231	30.4381	28.6816	28.5747	29.3155
450196	1.4787	0.8018	25.4842	29.8107	34.5610	29.7868
450200	1.5357	0.8018	27.9843	27.5112	27.4356	27.6508
450201	***	*	22.5464	*	*	22.5464
450203	1.3080	0.9427	28.0986	29.4706	30.6946	29.4199
450209	1.8635	0.8574	31.9882	30.4150	32.0113	31.4497
450210	1.0230	0.8169	22.9055	23.7777	24.1082	23.5571
450211	1.4423	0.8593	28.8485	27.7427	28.6208	28.3857
450213	1.9743	0.9071	28.0307	29.2061	31.8766	29.7730
450214	1.2952	0.9946	28.2261	27.0761	29.7013	28.2460
450219	0.9672	0.8018	24.7274	28.0584	26.5426	26.4061
450221	1.0166	0.8018	20.7118	23.9462	26.0548	23.4307
450222	1.8038	0.9946	31.9255	33.2164	35.4314	33.5503
450224	1.3332	0.8259	28.7931	29.8428	34.2896	30.7490
450229	1.6776	0.8416	26.8039	27.2189	28.6814	27.5782
450231	1.7396	0.8574	27.0545	27.7289	29.0463	27.9560
450234	1.1803	0.8018	21.6799	23.2715	24.5744	23.0923
450235	0.9372	0.8018	23.8001	24.3335	26.5480	24.8876
450236	1.2391	0.8407	24.5942	24.1409	24.7381	24.4954
450237	1.6644	0.9071	31.2197	36.8412	38.6993	35.7648
450239	0.9838	0.8775	18.4234	19.1203	20.1484	19.2749

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450241	1.0529	0.8018	28.4948	24.3518	23.6473	25.3644
450243	1.0338	0.8018	19.0180	19.9804	19.3327	19.4422
450253	0.8658	0.9946	22.9918	24.3618	24.8454	24.0810
450270	1.2977	0.8289	12.9999	19.0341	23.1601	17.6868
450271	1.3816	0.9427	23.9534	27.4614	27.2326	26.3228
450272	1.2457	0.9523	29.0917	29.5124	30.9357	29.8687
450280	1.6447	0.9734	34.9349	33.8297	36.7763	35.1896
450283	1.1064	0.9584	28.2094	24.3428	26.0914	26.1061
450289	1.5582	0.9946	32.6137	32.4591	33.0717	32.7210
450292	1.2182	0.9734	29.0243	29.2485	29.9357	29.4213
450293	0.7961	0.8018	24.1556	23.7577	24.0607	23.9932
450296	1.0761	0.9946	33.4545	34.1708	36.4604	34.6820
450299	1.6942	0.9244	29.4593	30.3493	31.1239	30.4022
450306	0.8749	0.8416	22.6818	25.9877	26.8169	25.0749
450315	2.1271	0.9734	31.4227	32.3840	33.7842	32.7212
450324	1.6326	0.9584	27.9899	26.8023	29.4539	28.0902
450330	1.3508	0.9946	27.7419	29.4471	30.3251	29.1461
450340	1.4176	0.8479	29.6617	28.7672	30.5815	29.6840
450346	1.5986	0.8456	24.8434	26.7809	28.3085	26.7155
450347	1.2930	0.9946	28.5789	30.0644	39.0879	31.7620
450348	0.8857	0.8018	22.6828	23.1190	24.9786	23.5721
450351	1.1747	0.9427	29.9598	30.3441	31.5335	30.6264
450352	1.1455	0.9734	27.6480	29.3516	30.7631	29.2850
450358	2.1150	0.9946	33.9103	36.9859	37.7186	36.2668
450369	0.8990	0.8018	24.1953	22.7433	26.2247	24.2072
450370	1.1848	0.9946	29.0816	28.8348	29.9689	29.2856
450372	1.3896	0.9734	30.9345	33.7023	35.7078	33.4644
450373	0.8488	0.8018	27.4251	25.3691	24.2932	25.7191
450378	***	*	33.0583	33.9891	36.4075	34.4205
450379	1.4175	0.9734	35.0637	35.9067	32.6271	34.4741
450388	1.7639	0.9071	29.5386	30.3720	31.6070	30.5182
450389	1.2142	0.9584	26.8499	24.6733	25.7364	25.7517
450393	***	*	39.0266	12.9286	27.1107	24.0530
450395	1.1582	0.8459	28.4272	27.2714	29.8846	28.5726
450399	0.8847	0.8018	20.6307	23.2716	22.6787	22.2015
450400	1.0362	0.9244	29.5020	29.8965	30.9996	30.1497
450403	1.5366	0.9734	31.7065	33.1710	35.4782	33.5113

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450411	1.0111	0.8018	21.7877	20.9108	22.4110	21.7020
450419	1.3410	0.9584	34.9972	33.6834	34.9747	34.5445
450422	1.2762	0.9734	32.4669	36.7309	34.1134	34.3580
450424	1.5450	0.9946	29.8290	32.4674	34.5569	32.3014
450431	1.7403	0.9523	28.5289	29.6446	30.6654	29.6328
450438	1.3139	0.9946	27.7734	25.1006	25.4692	26.1366
450446	0.8334	0.9946	15.4641	12.4405	15.5216	14.4421
450447	1.1936	0.9584	28.3724	29.9936	31.8935	29.9931
450451	1.0730	0.8554	25.8836	26.5422	31.4824	27.8675
450460	0.8984	0.8071	25.2165	27.6224	25.4765	26.1120
450462	1.7382	0.9734	30.6516	31.7311	33.7989	32.0439
450465	1.2421	0.9946	28.1853	28.0105	30.1955	28.8001
450469	1.5261	0.9584	31.1348	29.2172	29.6203	29.9824
450475	1.1705	0.8593	24.7037	25.0642	25.7533	25.1909
450484	1.5134	0.8593	27.7792	29.4306	31.9711	29.7496
450488	1.1850	0.8593	24.9109	26.6089	19.2414	24.1030
450489	1.0148	0.8018	26.9543	25.3695	27.9844	26.7321
450497	1.0021	0.8393	23.0712	24.6056	25.5912	24.4315
450498	0.9124	0.8018	20.6873	19.3077	20.7519	20.2120
450508	1.4192	0.8593	29.1519	30.4829	31.5816	30.4268
450514	***	*	26.4196	*	*	26.4196
450518	1.4458	0.8456	27.5880	28.9969	30.5901	29.0765
450530	1.3988	0.9946	30.7745	31.5033	33.7675	32.0278
450537	1.6268	0.9734	30.9167	33.1500	33.2793	32.4461
450539	1.2570	0.8085	25.0191	25.5268	27.9134	26.1684
450547	0.9127	0.9584	25.4140	24.6575	25.2773	25.1206
450558	1.7520	0.8416	28.7747	30.9433	32.3359	30.6894
450563	1.5978	0.9584	32.6875	35.8856	35.5273	34.6996
450565	1.3413	0.9427	27.4774	28.0400	20.2604	24.6775
450571	1.6736	0.8479	26.5313	26.2046	29.0276	27.1996
450573	1.0624	0.8144	24.6750	28.8508	27.5686	27.0771
450578	0.9388	0.8018	25.2478	25.7938	24.6928	25.2301
450580	0.9863	0.8018	25.9881	23.7932	24.3360	24.7329
450584	1.0404	0.8018	23.6044	23.7329	23.9279	23.7525
450586	1.0322	0.8018	18.3289	19.8656	21.2418	19.8421
450587	1.1286	0.8018	25.9364	27.1505	29.0095	27.3368
450591	1.2132	0.9946	27.9867	26.8802	27.3228	27.3932

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450596	1.3215	0.9427	31.6590	30.9701	32.6451	31.7682
450597	0.9543	0.8021	24.8443	26.3300	28.5346	26.5850
450604	1.5282	0.9071	29.1543	27.9983	29.6711	28.9317
450605	1.0389	0.8576	14.8039	23.3169	25.9294	19.8604
450610	1.6708	0.9946	30.5977	32.1314	33.4177	32.0231
450615	0.9227	0.8018	22.6331	25.1269	24.9073	24.2185
450617	1.6748	0.9946	30.2923	31.5691	32.8524	31.6194
450620	0.8835	0.8018	21.2535	21.7871	21.8114	21.6178
450630	1.5995	0.9946	31.8014	32.3195	33.9731	32.6640
450634	1.6926	0.9734	31.8008	31.9667	35.0494	32.9472
450638	1.7216	0.9946	33.3237	34.1802	33.8596	33.7803
450639	1.5533	0.9584	34.3754	33.3962	35.2238	34.3245
450641	0.9255	0.8393	21.7292	20.0231	21.9208	21.2237
450643	1.4481	0.8312	27.2538	28.7747	28.9744	28.3464
450644	1.6896	0.9946	31.6874	33.5265	34.8463	33.3746
450646	1.6538	0.8594	27.4631	27.8352	29.9319	28.4242
450647	1.9676	0.9734	34.1016	35.2696	36.5367	35.3425
450651	1.6423	0.9734	33.6498	34.9917	35.6621	34.7071
450653	1.1352	0.8018	26.5361	27.8569	30.2644	28.1938
450654	0.9530	0.8018	25.0755	23.5856	24.5622	24.3772
450656	1.4433	0.8593	29.7290	30.0651	32.2787	30.6407
450658	1.0226	0.8018	22.7090	21.8183	23.5451	22.6654
450659	1.6318	0.9946	34.2657	35.0007	37.4041	35.4287
450661	1.6239	0.9426	29.2381	29.1701	32.8505	30.5685
450662	1.7067	0.9486	30.9630	32.8936	34.5875	32.8475
450668	1.5975	0.8594	30.2083	30.7673	32.0366	30.9613
450669	1.2140	0.9734	32.1244	32.6777	35.4345	33.3993
450670	1.6341	0.9946	26.2954	28.8285	30.3037	28.5168
450672	1.8489	0.9584	33.0858	34.5171	35.3309	34.3346
450674	0.9275	0.9946	31.9316	33.4719	34.3708	33.2937
450675	1.5462	0.9584	32.6380	34.4049	35.3618	34.1567
450677	1.3956	0.9584	27.1603	29.5819	31.0723	29.3313
450678	1.6140	0.9734	33.5513	33.6167	35.4020	34.2062
450683	1.2254	0.9734	24.8440	28.7984	29.3788	27.6756
450684	1.5209	0.9946	31.2765	31.8794	35.0768	32.7040
450686	1.7733	0.8940	26.4871	28.8211	30.3945	28.6469
450688	1.5690	0.9734	29.4393	30.4156	39.5212	33.4935

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450690	1.4264	0.8259	30.0577	31.8607	33.2142	31.5431
450694	1.1250	0.8018	27.0862	28.3456	29.6365	28.3309
450697	1.6210	0.9071	28.3002	29.0148	30.4461	29.3085
450698	0.9036	0.8145	23.3062	21.5450	22.3625	22.2982
450702	1.6646	0.8593	27.1318	26.9753	30.2610	28.1063
450709	1.5374	0.9946	31.3239	31.0331	32.2101	31.5528
450711	1.6479	0.8888	28.1040	29.2934	31.1833	29.5133
450713	1.7474	0.9523	30.4933	31.3274	32.4793	31.4789
450715	***	*	*	27.0982	*	27.0982
450716	1.4846	0.9946	33.9926	33.4960	35.7265	34.4031
450718	1.6829	0.9523	29.7609	30.6623	32.6777	31.1373
450723	1.5586	0.9734	31.0481	32.1316	32.6655	31.9568
450730	1.5137	0.9734	32.8920	34.9137	33.1903	33.6228
450742	1.2662	0.9734	30.4204	31.4270	33.0463	31.6358
450743	1.4816	0.9734	29.5098	30.3302	31.3249	30.4344
450746	1.1292	0.8018	23.3484	22.7535	25.0694	23.7092
450747	1.2515	0.8259	28.3935	27.1975	28.8858	28.1491
450749	0.9107	0.8018	23.9269	23.0265	23.2733	23.4142
450754	0.9768	0.8018	22.8572	23.4607	24.3117	23.5585
450755	1.0767	0.8294	24.7428	22.4195	31.3204	25.7528
450758	***	*	28.3305	29.5013	28.2010	28.6514
450760	***	*	23.7157	24.0691	25.7775	24.3542
450766	1.9556	0.9734	31.2084	33.3435	35.1683	33.2474
450770	1.3684	0.9523	23.6093	25.5863	18.0459	22.2518
450771	1.6045	0.9734	32.5014	32.6206	33.7565	32.9584
450774	1.6654	0.9946	27.5065	29.1151	*	28.3542
450775	1.5260	0.9946	31.6656	33.1582	34.3654	33.1091
450779	1.4365	0.9584	32.0770	31.4350	31.9592	31.8179
450780	2.1639	0.9071	28.5560	29.4960	31.6556	29.8709
450788	1.6154	0.8576	29.7667	31.5593	32.7687	31.3701
450795	1.1190	0.9946	43.8574	31.1871	28.4802	34.7233
450796	2.6228	0.8574	39.4762	31.6590	33.6154	34.7499
450797	1.7663	0.9946	26.0302	29.7074	31.7739	29.3070
450801	1.6105	0.8018	25.6379	27.2635	26.6634	26.5192
450803	1.3194	0.9946	28.7041	28.4345	33.0146	29.9070
450804	2.0163	0.9946	31.1891	33.2767	34.1951	32.9236
450808	2.3057	0.9523	29.6476	27.4132	29.9055	29.0173

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450809	1.7258	0.9523	29.4696	30.4031	31.4588	30.4836
450811	***	*	31.3007	32.5513	31.9859	31.9444
450813	1.1372	0.8144	26.5803	24.0804	20.6715	23.5616
450820	1.7477	0.9946	34.7445	36.4796	38.2108	36.6079
450822	1.3504	0.9734	34.4060	34.7760	36.6675	35.3212
450824	2.6197	0.9523	31.8413	34.8301	39.0190	35.1987
450825	1.6530	0.8888	25.8006	23.6674	24.3308	24.5730
450827	1.4304	0.9929	24.3659	23.6628	23.9496	23.9877
450828	1.3734	0.8018	26.9553	26.3231	28.2632	27.1681
450830	0.9681	*	28.4007	*	*	28.4007
450831	1.7089	0.9946	24.4141	24.2732	29.1549	25.8378
450832	1.5453	0.9946	28.1389	31.2830	32.4824	30.7550
450833	1.1420	0.9734	29.0256	30.3604	32.5010	30.7618
450834	1.7933	0.9244	26.7253	28.1564	29.1031	27.9224
450838	***	*	19.2949	20.3039	19.0487	19.5634
450839	1.0081	0.8018	27.5330	28.0060	28.5894	28.0255
450840	1.2748	0.9734	32.4162	34.1412	35.8725	34.2963
450841	1.6187	0.9486	24.4389	24.6321	23.9682	24.3370
450844	1.4764	0.9946	33.0758	34.7070	36.5371	34.8354
450845	1.8367	0.8594	28.5039	30.9556	31.2402	30.2207
450847	1.3939	0.9946	30.7431	31.6028	32.1869	31.6098
450848	1.4727	0.9946	31.1476	32.0471	33.4153	32.3022
450850	***	*	27.2653	*	*	27.2653
450851	2.0867	0.9734	32.8377	35.2085	38.8802	35.5622
450853	2.0083	0.9734	38.3600	37.5237	36.5101	37.2120
450855	1.8608	0.9486	30.7353	33.0196	32.9107	32.1835
450856	2.5479	0.9071	35.5006	35.5221	33.9274	34.9300
450860	1.8566	0.9946	33.3404	36.0060	39.5352	36.4526
450862	1.8415	0.9946	33.7962	34.2163	35.3982	34.5218
450864	2.6098	0.8259	25.3535	26.6579	27.1210	26.4353
450865	1.1060	0.9523	31.9200	34.6338	35.8513	34.1920
450867	1.2922	0.9523	31.4953	33.8712	34.7654	33.3974
450868	***	*	27.7501	28.4524	30.9119	29.0597
450869	1.9926	0.8888	28.7422	27.9532	33.2135	30.1400
450871	1.9451	0.9523	32.3990	35.2470	37.9738	35.1792
450872	1.3983	0.9584	31.7345	30.7510	30.9726	31.1239
450874	1.8676	0.9734	35.6839	37.4432	36.9974	36.7518

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450875	1.9516	0.8574	23.2962	26.9904	20.1676	22.8117
450876	1.7122	0.8940	30.3515	30.7721	30.9806	30.7060
450877	1.5299	0.8594	29.2353	28.0504	28.0186	28.4103
450878	2.5973	0.9071	33.6269	33.5225	36.1310	34.4610
450879	***	*	36.4874	31.1510	33.9546	33.6692
450880	1.9228	0.9584	32.6713	32.1245	34.4319	33.1600
450883	1.9373	0.9734	37.1525	38.5954	37.3049	37.6847
450884	1.0402	0.8642	23.5799	25.0230	25.7645	24.7956
450885	1.5264	0.9734	36.0954	33.7612	36.0679	35.3127
450886	2.1922	0.9584	30.1571	33.2011	34.2513	32.5780
450887	***	*	25.5590	*	*	25.5590
450888	1.9205	0.9451	28.5995	26.3027	33.6718	29.5947
450889	1.3218	0.9734	35.6151	29.1149	37.7768	33.7885
450890	1.6403	0.9734	32.2000	33.9068	30.5718	32.1704
450891	1.8038	0.9734	39.0890	29.7832	28.6689	31.5429
450892	***	*	39.5333	*	*	39.5333
450893	1.6541	0.9734	36.2660	37.8279	38.4890	37.6102
450894	2.5125	0.9734	25.9441	34.3388	30.1201	30.2587
460001	2.0520	0.9273	30.7040	32.3262	33.1209	32.1021
460003	1.6576	0.9362	29.6450	31.8128	33.2304	31.5395
460004	1.8788	0.9362	29.8773	32.2759	33.1810	31.8222
460005	1.5680	0.9362	29.4188	29.6947	32.5526	30.5747
460006	1.7333	0.9362	28.9653	30.3798	31.5156	30.3358
460007	1.3358	0.9311	29.1191	30.8583	31.3963	30.5244
460008	***	*	27.6906	30.5351	31.2708	29.8198
460009	2.0509	0.9362	29.4705	31.5120	32.4915	31.2060
460010	2.0371	0.9362	30.9813	32.8157	33.5686	32.4990
460011	1.3290	0.8714	26.5486	27.0189	29.7484	27.7675
460013	1.5423	0.9273	29.7252	31.2945	33.2639	31.4115
460014	1.1697	0.9362	30.6450	30.0229	31.5876	30.7603
460015	1.4935	0.8843	28.8014	30.7369	31.4843	30.3806
460017	1.3823	0.9097	28.7126	29.8556	32.9922	30.5250
460018	1.0014	*	22.0935	24.7761	*	23.4535
460019	1.1788	0.8714	25.1615	24.9579	29.0338	26.4222
460021	1.9540	0.9311	29.7397	31.5207	32.5066	31.3092
460023	1.4134	0.9273	28.9473	30.5888	31.3338	30.3465
460026	0.9596	0.9272	29.2775	31.3552	32.2647	30.9963

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
460030	1.1661	0.8714	26.8979	30.0714	29.9269	28.9836
460033	0.9059	0.8714	27.9108	29.0346	30.0615	29.0242
460035	0.9434	0.8714	23.8682	23.4736	25.1957	24.1858
460039	1.1592	0.9354	30.0677	32.8010	35.0008	32.6853
460041	1.4984	0.9362	26.7356	29.4568	30.8887	29.0180
460042	1.5807	0.9362	36.2903	35.5686	32.3029	34.4949
460043	0.8631	0.9273	29.5660	31.2717	32.7481	31.2613
460044	1.4132	0.9362	29.5079	31.4469	32.6644	31.2589
460047	1.7647	0.9362	31.0020	33.0291	35.1263	33.0272
460049	2.1169	0.9362	28.6267	32.0329	32.9633	31.2669
460051	1.5507	0.9362	28.1140	28.6559	29.4759	28.9591
460052	1.7033	0.9273	28.7455	30.2613	31.8515	30.3626
460054	1.5710	0.8843	26.3939	28.1478	28.0120	27.5238
460055	***	*	*	*	23.1431	23.1431
460056	0.8224	0.8714	*	*	*	*
470001	1.3548	1.0071	32.2887	34.5891	33.5241	33.3804
470003	1.7940	1.0340	30.0535	35.8753	36.7362	34.6784
470005	1.3682	0.9465	33.9969	32.1087	32.9379	33.0059
470011	1.2239	0.9465	30.8742	32.1668	33.3394	32.1525
470012	1.2953	1.0158	29.8259	30.9839	32.7025	31.2202
470024	1.3785	1.0340	27.3106	28.9203	29.2657	28.4919
490001	1.1846	0.8060	24.6883	25.2705	26.8850	25.6328
490002	0.9564	0.8063	24.0672	26.2533	27.6367	26.0235
490004	1.4283	0.9243	28.8660	30.6657	32.4538	30.6807
490005	1.7029	1.0559	31.4909	32.7159	34.9053	33.0668
490007	2.0623	0.8953	30.7411	31.5954	32.4614	31.6048
490009	2.0440	0.9243	31.4260	30.5748	31.9496	31.3136
490011	1.7060	0.8953	28.8780	30.5522	31.9508	30.4122
490012	1.1797	0.8060	21.8322	22.3339	24.4301	22.9678
490013	1.3615	0.9661	27.3486	27.4108	28.5324	27.7697
490017	1.6019	0.8953	29.6784	29.5853	30.9047	30.0811
490018	1.3937	0.9243	27.8682	28.8491	29.5589	28.7713
490019	1.3345	0.9243	29.8891	33.5636	33.7765	32.4062
490020	1.3546	0.9536	30.6013	32.5621	33.3461	32.1198
490021	1.4713	0.8527	28.1254	28.1343	30.0869	28.7596
490022	1.5783	1.0559	31.7985	34.5366	33.3639	33.2694
490023	1.4038	1.0559	32.6308	33.4561	35.6316	33.9527

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
490024	1.7367	0.9020	29.0407	29.9188	31.4854	30.2069
490027	1.4257	0.8060	24.3834	23.6876	25.1699	24.4425
490032	2.0641	0.9536	28.0120	30.0331	32.8661	30.3741
490033	1.2418	1.0559	30.9910	32.1854	35.3543	32.8355
490037	1.1921	0.8060	26.2951	28.9020	27.7807	27.6377
490038	1.1365	0.8063	24.0852	25.7219	26.5823	25.5525
490040	1.6870	1.0559	35.6822	36.5546	38.2247	36.8591
490041	1.7419	0.8953	29.1244	30.4198	31.6506	30.4422
490042	1.3852	0.8864	26.6078	28.1989	28.6351	27.8261
490043	1.4528	1.0571	36.5982	33.4364	35.4380	35.1246
490044	1.5021	0.8953	24.1763	30.3606	31.1639	28.6723
490045	1.4362	1.0559	32.8774	34.0289	33.2301	33.3822
490046	1.5611	0.8953	29.3882	30.5445	32.0244	30.6581
490048	1.5181	0.9020	28.0320	29.1952	32.3457	29.8101
490050	1.6932	1.0559	31.1370	33.3979	35.3441	33.2738
490052	1.7570	0.8953	25.4179	26.5858	27.5800	26.5238
490053	1.2123	0.8060	24.6206	25.5300	27.6516	26.0148
490057	1.6341	0.8953	29.0700	30.5163	31.4342	30.3581
490059	1.7476	0.9536	32.1031	32.7894	33.7315	32.8906
490060	1.0988	0.8060	25.7765	26.2620	26.8764	26.2885
490063	1.9288	1.0571	34.1179	35.7722	36.5676	35.5145
490066	1.3993	0.9536	31.4298	31.1949	32.8018	31.8232
490067	1.3116	0.9536	26.7802	27.5172	28.6635	27.6322
490069	1.7572	0.9536	30.1482	33.1140	33.7580	32.4106
490071	***	*	33.7118	36.1311	37.5474	35.7436
490073	***	*	46.4210	*	*	46.4210
490075	1.4728	0.8168	27.3424	27.8663	28.5221	27.8788
490077	1.4245	0.9243	31.0016	33.5266	33.9868	32.8758
490079	1.2258	0.8973	24.2066	25.3814	26.8381	25.4605
490084	1.1514	0.8247	26.3234	28.0861	29.2001	27.8967
490088	1.0343	0.8527	26.0285	26.5138	27.3105	26.6200
490089	1.0904	0.9020	27.4587	28.7200	28.6746	28.3003
490090	1.1170	0.8060	27.0760	28.1280	30.1159	28.4491
490092	1.0905	0.8060	27.5277	26.9546	27.9480	27.4786
490093	1.5805	0.8953	28.7122	29.2159	30.8707	29.6194
490094	1.0446	0.9536	29.7990	33.4960	35.2427	32.9163
490097	1.1213	0.8060	27.4608	27.3832	30.3702	28.3815

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
490098	1.2490	0.8060	26.7152	29.1195	30.2724	28.7604
490101	1.5529	1.0571	32.9516	36.2501	37.1100	35.5137
490104	0.8635	0.9536	19.0056	21.5140	25.4797	21.5647
490105	0.7752	0.8063	*	*	*	*
490106	0.7217	*	26.2318	28.0073	29.6648	27.8955
490107	1.5612	1.0571	35.0272	36.5156	37.8948	36.4952
490108	0.9350	0.8527	27.8717	26.8474	28.1422	27.6252
490109	0.8360	0.8953	21.6711	26.3100	35.3956	26.6243
490110	1.4981	0.8478	26.3089	28.6114	30.4140	28.4403
490111	1.3002	0.8060	26.4297	25.9801	25.5933	26.0180
490112	1.8616	0.9536	31.2549	32.6940	34.4483	32.7850
490113	1.3453	1.0559	34.7841	34.3609	35.7020	34.9658
490114	1.2877	0.8060	23.0533	23.6217	24.3756	23.7176
490115	1.1261	0.8060	23.2118	24.2056	24.5732	24.0079
490116	1.1200	0.8060	25.0351	26.8981	27.6062	26.5245
490117	1.1400	0.8060	20.3038	19.0627	21.2554	20.2023
490118	1.7126	0.9536	31.2407	32.7697	34.4087	32.7699
490119	1.3791	0.8953	29.5222	30.2401	31.8001	30.5988
490120	1.5447	0.8953	27.1990	29.8199	31.3588	29.5073
490122	1.6804	1.0571	35.2234	36.8356	37.2409	36.4506
490123	1.1733	0.8060	24.6011	25.9018	26.5759	25.6908
490126	1.2835	0.8060	25.3294	26.4277	28.1112	26.5960
490127	1.1572	0.8060	23.1399	23.5161	25.8521	24.1618
490130	1.3539	0.8953	25.9782	27.8912	28.5506	27.5060
490134	0.8484	0.8060	31.1495	36.6290	38.4799	35.3431
490135	0.8329	0.9020	27.2795	29.4817	30.6983	29.1252
490136	1.5986	0.9536	31.2911	33.2256	33.6199	32.9138
490137	***	*	*	33.7203	*	33.7203
490138	***	*	*	*	29.6062	29.6062
490140	1.1707	1.0559	*	*	*	*
500001	1.6920	1.1393	37.5323	34.4057	36.7516	36.1864
500002	1.4064	1.0107	30.1872	32.8317	34.4481	32.6052
500003	1.3883	1.1272	32.7983	34.5869	35.4284	34.3657
500005	1.9139	1.1393	36.0918	36.7598	34.3832	35.6947
500007	1.3046	1.1272	31.0313	32.8189	34.5520	32.8250
500008	2.0942	1.1393	34.7810	37.6578	39.2151	37.2339
500011	1.5112	1.1393	38.3979	35.9571	39.3411	37.8813

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
500012	1.6682	1.0107	33.1685	34.1650	36.8979	34.8623
500014	1.7774	1.1393	37.2698	36.3915	39.1505	37.5950
500015	1.4145	1.1393	40.8683	41.8914	37.7765	39.9793
500016	1.7006	1.1272	34.2828	35.1946	36.9961	35.5244
500019	1.2954	1.0238	33.8882	33.3151	33.7113	33.6367
500021	1.2735	1.1272	33.5610	34.1696	35.5039	34.4442
500024	1.6970	1.1080	37.4529	38.1144	38.4388	38.0019
500025	2.0660	1.1393	44.7105	45.7929	46.4667	45.6979
500026	1.5246	1.1393	35.5080	38.9294	39.8935	38.0803
500027	1.5514	1.1393	42.4974	43.3521	46.0534	43.9702
500030	1.6107	1.1302	36.9489	37.8938	39.5003	38.1941
500031	1.3816	1.1015	34.1651	37.1418	39.3882	37.0143
500033	1.3025	1.0107	32.6753	33.5611	34.6180	33.6561
500036	1.3062	1.0107	31.9164	33.0937	34.4581	33.2430
500037	1.0522	1.0107	29.1773	31.5221	33.5698	31.4598
500039	1.6290	1.1272	34.5739	35.7525	36.9804	35.8188
500041	1.4539	1.1212	36.9273	37.1754	37.2841	37.1483
500044	1.8709	1.0588	32.0743	32.9066	37.2547	34.2357
500049	1.3589	1.0107	30.8135	32.9904	35.3710	33.0668
500050	1.6841	1.1212	35.7254	35.8576	38.7771	36.8297
500051	1.7983	1.1393	36.4764	38.1805	40.4444	38.4149
500052	0.5257	1.1393	*	*	*	*
500053	1.2927	1.0107	28.5664	35.5776	32.3889	32.3866
500054	2.0439	1.0588	34.8114	36.0163	37.0037	35.9970
500058	1.7819	1.0107	32.6843	33.9116	35.3683	34.0086
500060	1.3839	1.1393	40.3040	33.4139	36.1561	36.3222
500064	2.1038	1.1393	34.7925	36.5889	38.6388	36.7061
500072	1.2795	1.0399	33.1148	33.7689	34.6614	33.8664
500077	1.6554	1.0588	34.3114	35.6352	36.5941	35.5623
500079	1.4615	1.1272	34.2420	35.0285	39.6971	36.2958
500084	1.2299	1.1393	33.3072	35.9603	37.4223	35.5895
500088	1.5216	1.1393	38.5194	39.5328	42.2213	40.1754
500108	1.7135	1.1272	35.8918	36.9874	38.4486	37.1566
500119	1.3965	1.0588	31.7125	33.2862	37.1560	34.2985
500124	1.5615	1.1393	36.3338	36.2555	38.4951	37.0807
500129	1.7301	1.1272	37.3189	39.0479	40.9416	39.1501
500134	***	*	28.9759	27.6000	*	28.2473

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
500139	1.5940	1.1080	37.5709	37.3065	40.1626	38.3039
500141	1.3018	1.1393	34.2384	35.0996	36.5770	35.3417
500143	0.8345	1.1080	26.3893	27.6976	27.0786	27.0516
500148	1.2582	1.0107	24.6347	29.1435	29.3580	27.8028
500150	1.3469	1.1212	34.8480	37.1238	39.5124	37.2763
500151	1.2724	1.1264	*	*	*	*
510001	1.9015	0.8266	26.7924	27.6648	28.5579	27.6991
510002	1.3699	0.8820	24.8846	25.3769	26.9879	25.7394
510006	1.3756	0.8266	26.6421	27.5033	28.3986	27.5167
510007	1.7093	0.8875	28.5783	29.7125	31.3109	29.8649
510008	1.4922	0.9455	27.4709	30.6397	31.5292	29.9314
510012	0.9949	0.7660	22.9038	23.9222	23.9062	23.5707
510013	1.1575	0.7536	22.9612	22.1864	22.8779	22.6690
510018	1.1130	0.8093	23.7736	22.6582	24.2196	23.5313
510022	1.8567	0.8093	27.6119	28.4911	28.9389	28.3550
510023	1.1934	0.7536	23.1461	21.1483	23.2098	22.4635
510024	1.6521	0.8266	31.1327	32.3022	29.9740	31.1328
510026	1.0087	*	17.8275	18.6662	*	18.2486
510029	1.4261	0.8093	25.3925	24.6743	25.6860	25.2487
510030	1.1745	0.7536	25.5600	26.0174	26.6707	26.0891
510031	1.6207	0.8093	26.7872	29.5993	29.4024	28.5765
510033	1.5597	0.7536	24.2839	24.4150	24.9115	24.5148
510038	1.1536	0.7536	21.7545	21.1103	22.4112	21.7748
510039	1.3776	0.7536	21.3819	21.7158	22.0335	21.7116
510046	1.4481	0.8020	24.7187	23.2634	24.7177	24.2383
510047	1.2916	0.8266	28.8794	30.0461	31.1243	30.0454
510048	1.3054	0.7536	23.6396	25.0987	26.5418	25.1357
510050	1.8089	0.8441	23.5794	24.3081	24.5207	24.1225
510053	1.0042	0.7536	22.6288	24.3853	25.0147	24.0222
510055	1.6973	0.8875	30.7382	32.3284	33.3163	32.1773
510058	1.3980	0.7536	24.8770	24.9360	23.8781	24.5564
510059	***	*	21.9053	20.5651	23.5300	22.1135
510062	1.2221	0.8093	27.7971	30.4515	32.4834	30.2773
510067	***	*	25.2248	25.4499	*	25.3238
510070	1.3121	0.8093	25.4981	26.1227	28.1871	26.6091
510071	1.3504	0.7746	23.4553	21.7085	23.4390	22.8860
510072	1.0600	0.7536	20.2387	20.1981	21.4895	20.6336

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
510077	1.0537	0.8723	27.1611	24.7849	27.0319	26.3370
510082	1.2339	0.7536	21.1665	24.7558	22.7658	22.9281
510085	1.4818	0.8093	26.8133	27.6206	24.4240	26.3575
510086	1.1482	0.7536	20.1965	21.2628	20.3576	20.5850
510090	***	*	39.0787	*	*	39.0787
520002	1.3482	0.9113	28.3413	28.2765	26.7116	27.7254
520004	1.4996	0.9864	30.9212	32.9848	34.1865	32.6654
520008	1.6075	1.0226	33.6774	36.6697	38.2815	36.3308
520009	1.8579	0.9375	29.6290	31.0683	31.6106	30.8052
520011	1.3433	0.9019	29.5024	31.8421	33.2873	31.5935
520013	1.6336	1.1027	32.1721	33.9209	34.9944	33.6882
520017	1.2107	0.9600	31.0537	31.8512	33.6624	32.2031
520019	1.2522	0.9019	30.2189	28.8256	25.1409	27.9904
520021	1.3391	1.0370	29.7809	29.0525	30.3673	29.7460
520027	1.4301	1.0226	33.5836	33.5264	35.9033	34.3676
520028	1.3940	1.1096	29.4694	28.1055	30.4362	29.3795
520030	1.7246	0.9581	31.6807	32.0646	34.2167	32.6070
520033	1.3879	0.9019	30.2631	29.5690	31.1389	30.3366
520034	1.3078	0.9019	28.1819	30.4913	31.6386	30.1603
520035	1.5330	0.9375	29.4076	31.0972	32.7626	31.1082
520037	1.7279	0.9113	32.2206	33.1606	33.0449	32.8212
520038	1.2914	1.0226	30.5267	32.6502	32.9167	32.0875
520040	***	*	35.9652	*	*	35.9652
520041	1.0128	1.1316	26.1586	28.3889	30.2068	28.2350
520044	1.5130	0.9375	28.6620	*	31.9599	30.2726
520045	1.7890	0.9536	30.0856	29.6250	33.3652	30.9444
520048	1.6586	0.9536	30.1483	31.8604	33.1944	31.7313
520049	1.9727	0.9443	29.4238	29.8707	30.8224	30.0316
520051	1.5852	1.0226	32.4131	32.5510	35.4345	33.4292
520057	1.2057	0.9212	29.1597	31.7777	34.0671	31.7455
520059	1.4262	1.0226	31.1798	32.1905	33.6526	32.3663
520062	1.3557	1.0226	32.7015	37.5630	37.0520	35.8645
520063	1.2023	1.0226	31.5200	32.6383	34.1781	32.7561
520064	1.6643	1.0226	33.1269	34.1899	36.0924	34.4301
520066	1.4525	0.9694	31.6793	31.2257	33.7033	32.1994
520070	1.8311	0.9600	30.0475	30.2454	32.1644	30.8209
520071	1.2720	1.0226	31.5452	32.9974	33.3852	32.6894

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
520075	1.8243	0.9443	32.2773	33.5393	34.0973	33.3083
520076	1.2579	1.0226	26.8943	28.0857	30.1903	28.4165
520078	1.6147	1.0226	32.0200	32.8377	33.6214	32.8336
520083	1.6732	1.1316	34.7230	36.8165	38.2281	36.6451
520087	1.6998	0.9864	31.9771	33.5759	34.5519	33.3848
520088	1.3791	0.9470	30.7482	32.9061	32.7670	32.1576
520089	1.5783	1.1316	34.9357	36.3819	38.0516	36.4973
520091	1.3243	0.9019	28.7180	29.9318	31.2611	29.9703
520095	1.2864	1.1096	33.2426	33.3298	35.6079	34.0578
520096	1.4255	1.0226	29.2895	31.5023	37.8499	32.7151
520097	1.4507	0.9443	30.5442	32.2225	34.3493	32.3376
520098	2.0458	1.1316	38.0993	39.1444	41.0919	39.4919
520100	1.3212	0.9694	31.7772	32.4038	34.0159	32.7405
520102	1.2714	1.0226	31.5756	31.9275	34.1568	32.5763
520103	1.5487	1.0226	34.5640	35.3825	36.9411	35.6386
520107	1.3724	0.9178	30.0354	31.6500	31.1976	30.9724
520109	1.0287	0.9019	25.9740	27.2739	28.4742	27.2711
520113	1.4088	0.9249	33.3040	34.9718	35.6843	34.6401
520116	1.2781	1.0226	31.6702	32.7105	34.6508	33.0184
520136	1.8091	1.0226	32.3504	32.8906	33.7189	32.9955
520138	1.9849	1.0226	32.5677	33.5487	36.0676	34.0683
520139	1.4138	1.0226	31.7086	32.9369	34.1039	32.9713
520160	1.7449	0.9375	30.3052	31.0392	33.4129	31.5467
520170	1.6326	1.0226	31.7610	35.2627	33.8589	33.5756
520177	1.7357	1.0226	33.1243	34.6960	35.6005	34.5408
520189	1.3474	1.0370	29.2229	29.0333	31.6752	29.9942
520193	1.7818	0.9443	29.4737	30.8077	32.6949	31.0673
520194	1.7194	1.0226	31.0015	36.9520	35.9064	34.6592
520195	***	*	41.6120	37.8891	*	39.7179
520196	1.7921	0.9600	33.4890	32.0197	35.9711	33.8028
520198	1.4018	0.9536	29.9803	30.6303	32.9887	31.2354
520199	2.1323	1.0226	37.0128	45.5967	46.6518	43.7293
520202	1.7481	0.9581	*	33.6427	30.8076	32.2276
520203	***	*	*	*	44.8123	44.8123
520204	1.0509	1.0226	*	*	*	*
520205	2.1096	1.0226	*	*	*	*
530002	1.1686	0.9392	29.2418	32.5654	34.0190	32.0426

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
530006	1.2785	0.9392	30.3724	32.8615	33.0523	32.1254
530008	1.1051	0.9392	30.6010	30.6600	30.9960	30.7519
530009	0.8427	0.9392	27.0555	27.3359	30.2467	28.1948
530010	1.2811	0.9392	28.5534	30.1134	32.0732	30.2646
530011	1.1057	0.9392	31.1329	31.8923	31.4146	31.4720
530012	1.6294	0.9444	30.6109	31.1738	32.9710	31.6237
530014	1.4706	0.9418	29.6724	31.2573	32.7666	31.2186
530015	1.2800	0.9392	33.4903	36.0871	37.1114	35.5281
530017	1.1557	*	25.8183	24.0911	*	24.8262
530025	1.2173	0.9392	28.8963	31.4614	30.9906	30.4574
530032	1.1632	0.9392	25.4267	26.7025	31.0922	27.6747
530033	2.0646	0.9444	*	*	*	*
640001	0.8536	*	*	*	*	*
650001	1.4006	*	*	*	*	*
660001	1.0796	*	*	*	*	*
670002	1.0505	0.9734	29.1376	29.9545	30.5438	29.8867
670003	***	*	33.8986	33.4713	33.2183	33.4927
670004	1.1660	0.8018	25.3706	25.5671	26.9631	25.9396
670005	1.7721	0.9946	31.9464	41.2085	29.7605	33.4908
670006	1.9552	0.9523	27.1064	34.6785	36.8199	32.5839
670007	***	*	*	29.5985	30.3445	30.0121
670008	1.5966	0.9946	*	30.3978	30.7957	30.6253
670009	***	*	*	31.8096	29.0715	30.1581
670010	0.8338	0.9734	*	35.6620	29.6612	31.5941
670011	1.0270	0.9523	*	32.1855	30.2158	30.9733
670012	2.2140	0.9946	*	24.1597	24.2305	24.1941
670013	***	*	*	29.4886	*	29.4886
670014	***	*	*	34.6108	*	34.6108
670015	***	*	*	35.3054	*	35.3054
670016	***	*	*	*	30.9543	30.9543
670017	***	*	*	*	30.4743	30.4743
670018	0.9687	0.9946	*	*	34.7939	34.7939
670019	1.5202	0.9946	*	*	42.1599	42.1599
670020	***	*	*	*	39.6181	39.6181
670022	***	*	*	32.9889	34.0570	33.5229
670023	1.4036	0.9427	*	*	32.5158	32.5158
670024	1.6178	0.9946	*	*	30.0165	30.0165
670025	3.0845	0.9734	*	*	39.9558	39.9558
670026	***	*	*	*	21.8681	21.8681
670027	1.9240	0.9946	*	*	19.3451	19.3451
670028	***	*	*	*	43.4052	43.4052
670029	1.7447	0.9946	*	*	24.7438	24.7438
670030	***	*	*	*	32.0527	32.0527
670031	1.3908	0.9946	*	*	32.9130	32.9130
670033	1.1449	0.9734	*	*	*	*
670034	1.4385	0.9523	*	*	31.7770	31.7770
670040	0.8256	0.9946	*	*	20.5126	20.5126
670041	1.5612	0.9523	*	*	*	*
670042	1.7645	0.9427	*	*	*	*
670043	1.2712	0.9523	*	*	*	*
670044	1.2345	0.9734	*	*	*	*
670046	1.2291	0.9427	*	*	*	*
670047	1.4178	0.8594	*	*	*	*
670048	1.2701	0.9946	*	*	*	*
670049	1.4828	0.9734	*	*	*	*
670050	1.2258	0.8940	*	*	*	*
670051	1.7132	0.9244	*	*	*	*
670052	0.9734	0.9427	*	*	*	*
670053	1.5075	0.9946	*	*	*	*
670054	2.1510	0.9071	*	*	*	*
670055	1.4073	0.9071	*	*	*	*

1. Based on salaries adjusted for occupational mix, according to the calculation in section III.H. of this proposed rule.
2. The case-mix index is based on the billed MS-DRGs in the FY 2009 MedPAR file. It is not transfer-adjusted.
3. Provider 140010 is part of a multi-campus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 140B10, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the MCH that is allocated to CBSA 16974.
4. Provider 220074 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 220B74, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the MCH that is allocated to CBSA 39300.
5. Provider 230104 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 230B04, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the MCH that is allocated to CBSA 19804.

Notes:

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2009, 2010, and 2011.
*** Denotes MedPAR data not available for the provider for FY 2009.

TABLE 3A.--FY 2011 and 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2009, 2010, and 2011.]

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
10180	Abilene, TX	29.3949	28.1776
10380	Aguadilla-Isabela-San Sebastián, PR	11.8160	11.2855
10420	Akron, OH	30.9394	29.7268
10500	Albany, GA	31.7616	30.0124
10580	Albany-Schenectady-Troy, NY	30.4027	29.4970
10740	Albuquerque, NM	33.6484	32.1367
10780	Alexandria, LA	28.4818	27.3679
10900	Allentown-Bethlehem-Easton, PA-NJ	32.9853	32.3982
11020	Altoona, PA	29.8723	28.7214
11100	Amarillo, TX	29.9470	29.2820
11180	Ames, IA	35.0846	32.5833
11260	Anchorage, AK	41.3142	39.7621
11300	Anderson, IN	32.4243	30.5946
11340	[1]Anderson, SC	----	31.0258
11460	Ann Arbor, MI	35.2875	34.4775
11500	Anniston-Oxford, AL	27.5967	26.3204
11540	Appleton, WI	32.6349	31.2420
11700	Asheville, NC	31.6157	30.6097
12020	Athens-Clarke County, GA	32.6369	31.0325
12060	Atlanta-Sandy Springs-Marietta, GA	33.4176	32.3815
12100	Atlantic City-Hammonton, NJ	38.5037	38.3789
12220	Auburn-Opelika, AL	26.2864	26.2272
12260	Augusta-Richmond County, GA-SC	33.4130	32.0531
12420	Austin-Round Rock-San Marcos, TX	33.2627	31.9957
12540	Bakersfield-Delano, CA	41.2731	38.7144
12580	Baltimore-Towson, MD	35.6052	33.9776
12620	Bangor, ME	33.8045	33.3702
12700	Barnstable Town, MA	44.7757	42.6501
12940	Baton Rouge, LA	30.4662	28.2098
12980	Battle Creek, MI	34.0719	33.4413
13020	Bay City, MI	32.9174	31.6784
13140	Beaumont-Port Arthur, TX	29.5372	28.3888
13380	Bellingham, WA	39.5003	38.1941
13460	Bend, OR	39.2471	37.6920
13644	Bethesda-Rockville-Frederick, MD	36.3603	34.8330
13740	Billings, MT	31.2292	30.2506
13780	Binghamton, NY	31.1847	29.8256
13820	Birmingham-Hoover, AL	30.1026	29.0144
13900	Bismarck, ND	26.6755	25.4947
13980	Blacksburg-Christiansburg-Radford, VA	28.9603	27.7355
14020	Bloomington, IN	32.4229	31.4114
14060	Bloomington-Normal, IL	33.4002	31.9474
14260	Boise City-Nampa, ID	32.4846	31.3466
14484	Boston-Quincy, MA	43.0901	41.0488
14500	Boulder, CO	35.3221	34.0847
14540	Bowling Green, KY	30.4559	28.6498
14740	Bremerton-Silverdale, WA	36.9804	35.8188
14860	Bridgeport-Stamford-Norwalk, CT	44.1289	43.0332
15180	Brownsville-Harlingen, TX	33.1329	31.3922
15260	Brunswick, GA	32.4958	31.8053
15380	Buffalo-Niagara Falls, NY	33.6124	32.5065
15500	Burlington, NC	30.6796	29.1889
15540	Burlington-South Burlington, VT	36.0988	34.0281
15764	Cambridge-Newton-Framingham, MA	39.4299	37.7800
15804	Camden, NJ	36.2670	34.9790
15940	Canton-Massillon, OH	30.1085	29.2640
15980	Cape Coral-Fort Myers, FL	32.0534	31.0627
16020	Cape Girardeau-Jackson, MO-IL	30.7590	30.1921
16180	Carson City, NV	35.8985	34.3321
16220	Casper, WY	32.9710	31.6237
16300	Cedar Rapids, IA	30.7335	29.6900
16580	Champaign-Urbana, IL	35.4749	33.2063
16620	Charleston, WV	28.2186	27.7498
16700	Charleston-North Charleston-Summerville, SC	32.4496	31.0970
16740	Charlotte-Gastonia-Rock Hill, NC-SC	32.4685	31.5651
16820	Charlottesville, VA	32.2777	31.5688
16860	Chattanooga, TN-GA	30.7014	29.7023
16940	Cheyenne, WY	32.7666	31.2186

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
16974	Chicago-Joliet-Naperville, IL	36.6687	34.9381
17020	Chico, CA	39.7055	37.2221
17140	Cincinnati-Middletown, OH-KY-IN	33.6443	32.0501
17300	Clarksville, TN-KY	27.4198	26.9255
17420	Cleveland, TN	27.2121	26.2003
17460	Cleveland-Elyria-Mentor, OH	31.7487	30.5792
17660	Coeur d'Alene, ID	32.1766	30.7795
17780	College Station-Bryan, TX	32.2874	30.8937
17820	Colorado Springs, CO	32.2511	31.9296
17860	Columbia, MO	28.8423	28.3106
17900	Columbia, SC	30.7179	29.8385
17980	Columbus, GA-AL	31.8363	30.1940
18020	Columbus, IN	33.0833	32.3322
18140	Columbus, OH	35.5317	33.8232
18580	Corpus Christi, TX	29.9543	28.8144
18700	Corvallis, OR	36.1111	36.0952
18880	[2]Crestview-Fort Walton Beach-Destin, FL	30.6368	29.2681
19060	Cumberland, MD-WV	28.7642	26.6875
19124	Dallas-Plano-Irving, TX	33.9994	32.8345
19140	Dalton, GA	29.6173	28.6311
19180	Danville, IL	33.9418	31.5446
19260	Danville, VA	28.5221	27.8788
19340	Davenport-Moline-Rock Island, IA-IL	29.4290	28.1402
19380	Dayton, OH	32.0635	31.0431
19460	Decatur, AL	26.2777	25.6527
19500	Decatur, IL	27.8420	27.0898
19660	Deltona-Daytona Beach-Ormond Beach, FL	30.6744	29.6824
19740	Denver-Aurora-Broomfield, CO	37.0948	35.6553
19780	Des Moines-West Des Moines, IA	33.2680	31.9747
19804	Detroit-Livonia-Dearborn, MI	34.0881	33.1008
20020	Dothan, AL	27.0561	25.7662
20100	Dover, DE	35.0266	34.3423
20220	Dubuque, IA	29.9069	28.4340
20260	Duluth, MN-WI	37.2948	35.6803
20500	Durham-Chapel Hill, NC	33.7364	32.4388
20740	Eau Claire, WI	33.5152	32.1516

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
20764	Edison-New Brunswick, NJ	38.0887	36.9892
20940	El Centro, CA	32.5187	30.4057
21060	Elizabethtown, KY	29.2425	28.1376
21140	Elkhart-Goshen, IN	32.9702	31.8127
21300	Elmira, NY	29.8159	28.3066
21340	El Paso, TX	30.0169	29.1999
21500	Erie, PA	29.1769	28.9316
21660	Eugene-Springfield, OR	39.5694	37.5142
21780	Evansville, IN-KY	29.3081	28.4396
21820	Fairbanks, AK	38.4880	37.2462
21940	Fajardo, PR	13.5864	13.1629
22020	Fargo, ND-MN	28.2861	27.3617
22140	Farmington, NM	27.9464	26.5665
22180	Fayetteville, NC	33.0069	32.2702
22220	Fayetteville-Springdale-Rogers, AR-MO	30.1927	29.7252
22380	Flagstaff, AZ	43.4901	40.9837
22420	Flint, MI	39.7366	37.7705
22500	Florence, SC	29.6001	28.2550
22520	Florence-Muscle Shoals, AL	27.7915	26.5477
22540	Fond du Lac, WI	32.7670	32.1576
22660	Fort Collins-Loveland, CO	33.2168	32.4365
22744	Fort Lauderdale-Pompano Beach-Deerfield	34.9003	33.5974
22900	Fort Smith, AR-OK	27.0278	26.3924
23060	Fort Wayne, IN	32.2565	30.3718
23104	Fort Worth-Arlington, TX	32.9268	31.9797
23420	Fresno, CA	39.9087	37.8308
23460	Gadsden, AL	24.8236	26.1400
23540	Gainesville, FL	32.8864	31.4434
23580	Gainesville, GA	33.8978	31.8764
23844	Gary, IN	31.4542	30.7534
24020	Glens Falls, NY	30.8219	29.5362
24140	Goldsboro, NC	32.4035	31.0271
24220	Grand Forks, ND-MN	28.0496	26.7628
24300	Grand Junction, CO	34.4738	32.8228
24340	Grand Rapids-Wyoming, MI	32.5225	31.2449
24500	Great Falls, MT	28.8603	28.2315

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
24540	Greeley, CO	33.5991	32.8595
24580	Green Bay, WI	32.9660	31.7777
24660	Greensboro-High Point, NC	31.4115	30.5532
24780	Greenville, NC	32.6226	31.4428
24860	Greenville-Mauldin-Easley, SC	32.6686	32.3059
25020	Guayama, PR	12.4886	11.4528
25060	Gulfport-Biloxi, MS	31.1513	29.7538
25180	Hagerstown-Martinsburg, MD-WV	33.1846	31.3132
25260	Hanford-Corcoran, CA	40.0252	37.9890
25420	Harrisburg-Carlisle, PA	32.1215	30.8066
25500	Harrisonburg, VA	32.4538	30.6807
25540	Hartford-West Hartford-East Hartford, C	38.8127	37.6851
25620	Hattiesburg, MS	27.7551	26.1804
25860	Hickory-Lenoir-Morganton, NC	30.2030	29.6952
25980	[1]Hinesville-Fort Stewart, GA	----	----
26100	Holland-Grand Haven, MI	30.7086	29.9212
26180	Honolulu, HI	40.6203	38.8534
26300	Hot Springs, AR	32.4533	30.8422
26380	Houma-Bayou Cane-Thibodaux, LA	27.9003	26.7495
26420	Houston-Sugar Land-Baytown, TX	34.7363	33.3876
26580	Huntington-Ashland, WV-KY-OH	31.1470	30.3284
26620	Huntsville, AL	31.4293	30.1542
26820	Idaho Falls, ID	33.7810	31.5660
26900	Indianapolis-Carmel, IN	33.3588	32.4485
26980	Iowa City, IA	33.3562	31.7675
27060	Ithaca, NY	34.1345	32.8690
27100	Jackson, MI	32.3303	30.8026
27140	Jackson, MS	28.3657	27.2938
27180	Jackson, TN	29.2532	28.4242
27260	Jacksonville, FL	31.1293	30.3737
27340	Jacksonville, NC	27.4651	27.2070
27500	Janesville, WI	33.8440	32.4434
27620	Jefferson City, MO	30.0429	29.6671
27740	Johnson City, TN	24.9085	25.3818
27780	Johnstown, PA	29.1342	27.8673
27860	Jonesboro, AR	27.3474	26.4977

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
27900	Joplin, MO	29.4636	29.6834
28020	Kalamazoo-Portage, MI	36.0038	35.2099
28100	Kankakee-Bradley, IL	36.9046	34.8205
28140	Kansas City, MO-KS	33.3682	31.9790
28420	Kennewick-Pasco-Richland, WA	34.3233	33.4579
28660	Killeen-Temple-Fort Hood, TX	30.6493	29.6099
28700	Kingsport-Bristol-Bristol, TN-VA	26.7971	26.4513
28740	Kingston, NY	31.9507	31.3235
28940	Knoxville, TN	27.4247	26.4301
29020	Kokomo, IN	31.4563	31.3022
29100	La Crosse, WI-MN	34.4391	33.1590
29140	Lafayette, IN	32.3043	30.6089
29180	Lafayette, LA	29.5826	28.5502
29340	Lake Charles, LA	28.6346	26.6076
29404	Lake County-Kenosha County, IL-WI	37.4834	35.3301
29420	Lake Havasu City-Kingman, AZ	35.9129	34.5415
29460	Lakeland-Winter Haven, FL	30.1679	29.0320
29540	Lancaster, PA	34.1814	32.6061
29620	Lansing-East Lansing, MI	35.8522	33.4940
29700	Laredo, TX	28.7425	28.4271
29740	Las Cruces, NM	31.8991	29.9182
29820	Las Vegas-Paradise, NV	41.2359	39.5656
29940	Lawrence, KS	29.7218	28.4175
30020	Lawton, OK	30.0871	28.4155
30140	Lebanon, PA	28.4545	28.6018
30300	Lewiston, ID-WA	32.0498	31.1265
30340	Lewiston-Auburn, ME	31.2669	30.6891
30460	Lexington-Fayette, KY	30.7246	29.8100
30620	Lima, OH	32.3533	31.2513
30700	Lincoln, NE	33.1312	31.8977
30780	Little Rock-N.Little Rock-Conway,AR	30.2877	29.2865
30860	Logan, UT-ID	30.8717	29.8653
30980	Longview, TX	30.0153	27.9402
31020	Longview, WA	37.2841	37.1483
31084	Los Angeles-Long Beach-Santa Ana, CA	41.8223	40.3432
31140	Louisville-Jefferson County, KY-IN	30.8966	30.1980

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
31180	Lubbock, TX	31.2259	29.6499
31340	Lynchburg, VA	29.7754	28.5576
31420	Macon, GA	32.7055	32.8408
31460	Madera-Chowchilla, CA	30.1104	28.6056
31540	Madison, WI	39.5054	37.8696
31700	Manchester-Nashua, NH	34.5930	33.9822
31740	Manhattan, KS	27.6635	26.5957
31860	Mankato-North Mankato, MN	32.3639	31.4358
31900	Mansfield, OH	30.7835	30.3015
32420	Mayagüez, PR	12.6118	12.4907
32580	McAllen-Edinburg-Mission, TX	31.0449	30.1056
32780	Medford, OR	35.0103	33.9125
32820	Memphis, TN-MS-AR	32.1641	31.1231
32900	Merced, CA	42.0265	40.4262
33124	Miami-Fort Lauderdale-Pompano Beach, FL	35.7435	33.7683
33140	Michigan City-La Porte, IN	32.8129	30.9515
33260	Midland, TX	33.3058	31.8597
33340	Milwaukee-Waukesha-West Allis, WI	35.6954	34.2353
33460	Minneapolis-St. Paul-Bloomington, MN-WI	38.4952	36.9220
33540	Missoula, MT	30.7656	29.8216
33660	Mobile, AL	27.6019	26.3141
33700	Modesto, CA	42.0519	41.0061
33740	Monroe, LA	28.3557	26.8341
33780	Monroe, MI	31.3315	30.3938
33860	Montgomery, AL	29.7248	28.3780
34060	Morgantown, WV	28.9024	28.5485
34100	Morristown, TN	24.8315	24.2612
34580	Mount Vernon-Anacortes, WA	35.1691	33.8802
34620	Muncie, IN	28.6143	27.7649
34740	Muskegon-Norton Shores, MI	34.3151	33.4379
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	30.3085	29.1823
34900	Napa, CA	50.6166	48.0443
34940	Naples-Marco Island, FL	34.2982	32.9979
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	32.5483	31.7724

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
35004	Nassau-Suffolk, NY	43.9572	42.5759
35084	Newark-Union, NJ-PA	39.5622	38.2213
35300	New Haven-Milford, CT	40.3584	39.1449
35380	New Orleans-Metairie-Kenner, LA	31.4388	30.2046
35644	New York-White Plains-Wayne, NY-NJ	45.9252	44.0840
35660	Niles-Benton Harbor, MI	31.3865	30.3136
35840	[2]North Port-Bradenton-Sarasota, FL	32.3943	31.9392
35980	Norwich-New London, CT	39.8427	38.5763
36084	Oakland-Fremont-Hayward, CA	55.5972	53.3129
36100	Ocala, FL	29.9935	28.8386
36140	Ocean City, NJ	38.0642	36.5086
36220	Odessa, TX	32.9220	32.1340
36260	Ogden-Clearfield, UT	32.6211	31.3730
36420	Oklahoma City, OK	31.0777	29.6784
36500	Olympia, WA	38.2620	37.6059
36540	Omaha-Council Bluffs, NE-IA	33.3566	31.9233
36740	Orlando-Kissimmee-Sanford, FL	32.0901	30.6557
36780	Oshkosh-Neenah, WI	33.2157	31.2415
36980	Owensboro, KY	29.7930	28.8753
37100	Oxnard-Thousand Oaks-Ventura, CA	43.2233	40.5774
37340	Palm Bay-Melbourne-Titusville, FL	32.6298	31.2779
37380	Palm Coast, FL	28.6480	29.3969
37460	Panama City-Lynn Haven-Panama City Beach, FL	28.4491	28.1718
37620	Parkersburg-Marietta-Vienna, WV-OH	25.9479	25.8732
37700	Pascagoula, MS	28.5637	27.4171
37764	Peabody, MA	38.4760	36.5635
37860	Pensacola-Ferry Pass-Brent, FL	28.4556	27.3708
37900	Peoria, IL	32.4315	31.0327
37964	Philadelphia, PA	37.7549	36.4016
38060	Phoenix-Mesa-Glendale, AZ	36.7246	35.1010
38220	Pine Bluff, AR	28.7130	26.7537
38300	Pittsburgh, PA	30.0448	28.9335
38340	Pittsfield, MA	36.5974	35.4692
38540	Pocatello, ID	32.7435	30.8807
38660	Ponce, PR	14.9358	14.1175

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
38860	Portland-South Portland-Biddeford, ME	34.6681	33.6576
38900	Portland-Vancouver-Hillsboro, OR-WA	39.1861	37.7069
38940	Port St. Lucie, FL	37.6301	34.3690
39100	Poughkeepsie-Newburgh-Middletown, NY	39.8644	37.7073
39140	Prescott, AZ	43.0057	36.4216
39300	Providence-New Bedford-Fall River, RI-M	37.5354	36.1121
39340	Provo-Orem, UT	32.3723	31.4543
39380	Pueblo, CO	30.0091	28.7443
39460	Punta Gorda, FL	31.7131	30.7467
39540	Racine, WI	37.1869	32.6652
39580	Raleigh-Cary, NC	33.9133	32.4239
39660	Rapid City, SD	38.3671	34.5099
39740	Reading, PA	31.0160	30.6990
39820	Redding, CA	47.5125	44.9345
39900	Reno-Sparks, NV	36.4465	34.9208
40060	Richmond, VA	33.2980	31.4929
40140	Riverside-San Bernardino-Ontario, CA	39.9014	37.9847
40220	Roanoke, VA	31.4982	29.9865
40340	Rochester, MN	37.5616	36.5729
40380	Rochester, NY	30.4032	29.5889
40420	Rockford, IL	35.0956	33.6906
40484	Rockingham County, NH	35.0486	33.6796
40580	Rocky Mount, NC	31.8553	30.3489
40660	Rome, GA	30.5837	30.5032
40900	Sacramento--Arden-Arcade--Roseville, CA	47.2994	45.2291
40980	Saginaw-Saginaw Township North, MI	32.1555	31.1518
41060	St. Cloud, MN	40.6853	39.1270
41100	St. George, UT	32.5066	31.3092
41140	St. Joseph, MO-KS	36.2278	34.8344
41180	St. Louis, MO-IL	31.6290	30.3438
41420	Salem, OR	38.8312	36.7534
41500	Salinas, CA	55.5109	51.7900
41540	Salisbury, MD	31.1946	30.3645
41620	Salt Lake City, UT	32.6863	31.4867
41660	San Angelo, TX	29.6151	28.0559
41700	San Antonio-New Braunfels, TX	31.6824	30.2027

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
41740	San Diego-Carlsbad-San Marcos, CA	40.5279	38.5285
41780	Sandusky, OH	30.0999	29.3797
41884	San Francisco-San Mateo-Redwood City, CA	53.8091	51.6664
41900	San Germán-Cabo Rojo, PR	15.9545	15.6643
41940	San Jose-Sunnyvale-Santa Clara, CA	57.4157	54.3198
41980	San Juan-Caguas-Guaynabo, PR	15.0192	14.6360
42020	San Luis Obispo-Paso Robles, CA	43.3776	40.8126
42044	Santa Ana-Anaheim-Irvine, CA	41.9435	39.8926
42060	Santa Barbara-Santa Maria-Goleta, CA	41.2648	39.8280
42100	Santa Cruz-Watsonville, CA	56.9566	54.4353
42140	Santa Fe, NM	37.6618	35.8749
42220	Santa Rosa-Petaluma, CA	55.3076	52.3185
42340	Savannah, GA	30.9240	29.9675
42540	Scranton--Wilkes-Barre, PA	28.7281	27.7860
42644	Seattle-Bellevue-Everett, WA	39.8184	38.4963
42680	Sebastian-Vero Beach, FL	32.4326	31.7794
43100	Sheboygan, WI	32.4662	30.8688
43300	Sherman-Denison, TX	29.4908	28.9887
43340	Shreveport-Bossier City, LA	30.2022	28.7466
43580	Sioux City, IA-NE-SD	31.3111	29.8813
43620	Sioux Falls, SD	32.7745	31.1879
43780	South Bend-Mishawaka, IN-MI	34.5236	32.8075
43900	Spartanburg, SC	31.7207	30.5331
44060	Spokane, WA	37.0084	35.4231
44100	Springfield, IL	31.2379	30.6699
44140	Springfield, MA	36.1737	35.1312
44180	Springfield, MO	29.3703	28.6119
44220	Springfield, OH	31.4540	29.8060
44300	State College, PA	30.2637	29.6045
44600	[2]Steubenville-Weirton, OH-WV	25.4395	25.3407
44700	Stockton, CA	43.8475	41.3450
44940	Sumter, SC	28.5579	28.2053
45060	Syracuse, NY	33.9000	32.9463
45104	Tacoma, WA	39.3681	37.5711
45220	Tallahassee, FL	31.4039	29.7448
45300	Tampa-St. Petersburg-Clearwater, FL	31.7974	30.3381

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
45460	Terre Haute, IN	32.3071	30.7568
45500	Texarkana, TX-Texarkana, AR	26.8927	26.8786
45780	Toledo, OH	32.7715	31.4781
45820	Topeka, KS	31.9034	30.4681
45940	Trenton-Ewing, NJ	35.1805	34.8810
46060	Tucson, AZ	33.8370	32.2980
46140	Tulsa, OK	31.0910	29.4632
46220	Tuscaloosa, AL	28.7402	29.0146
46340	Tyler, TX	28.7095	28.5924
46540	Utica-Rome, NY	30.4893	29.2712
46660	Valdosta, GA	28.3875	27.3859
46700	Vallejo-Fairfield, CA	50.8429	48.5255
47020	Victoria, TX	28.0779	26.7203
47220	Vineland-Millville-Bridgeton, NJ	38.1019	36.3949
47260	Virginia Beach-Norfolk-Newport News, VA	31.2647	29.9721
47300	Visalia-Porterville, CA	38.0071	35.3637
47380	Waco, TX	30.2079	29.0730
47580	Warner Robins, GA	29.2281	30.2010
47644	Warren-Troy-Farmington-Hills, MI	33.9524	33.0850
47894	Washington-Arlington-Alexandria DC-VA	36.8726	35.7731
47940	Waterloo-Cedar Falls, IA	29.6525	28.7768
48140	Wausau, WI	33.4493	32.5485
48300	Wenatchee-East Wenatchee, WA	33.8234	32.3786
48424	West Palm Beach-Boca Raton-Boynton FL	34.3519	32.7302
48540	Wheeling, WV-OH	23.4746	23.0898
48620	Wichita, KS	30.9307	30.0110
48660	Wichita Falls, TX	34.6795	32.0396
48700	Williamsport, PA	25.4029	25.8954
48864	Wilmington, DE-MD-NJ	37.7128	36.0069
48900	Wilmington, NC	32.2983	30.6626
49020	Winchester, VA-WV	34.9053	33.0668
49180	Winston-Salem, NC	31.3330	30.1817
49340	Worcester, MA	39.1354	37.4410
49420	Yakima, WA	35.0663	33.5431
49500	Yauco, PR	12.3738	11.4462
49620	York-Hanover, PA	33.4110	31.9488
49660	Youngstown-Warren-Boardman, OH-PA	30.1643	29.3613
49700	Yuba City, CA	37.6504	36.6555
49740	Yuma, AZ	33.0103	32.0532

[1] This area has no average hourly wage because there are no short-term, acute care hospital wage data for the area.
[2] This is a new CBSA for FY 2011. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for FY 2009 and FY 2010.

TABLE 3B.--FY 2011 AND 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITLAS IN RURAL AREAS BY CBSA

(*Based on the sum of the salaries and hours computed for Federal FYs 2009, 2010, and 2011.)

CBSA Code	Nonurban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
01	Alabama	26.0264	25.1568
02	Alaska	44.1146	40.4763
03	Arizona	31.8393	29.9784
04	Arkansas	25.9685	25.2920
05	California	42.9541	40.4802
06	Colorado	33.8979	32.2217
07	Connecticut	39.4836	37.7398
08	Delaware	34.5676	33.5989
10	Florida	29.5728	28.7958
11	Georgia	27.1671	26.2403
12	Hawaii	39.4229	37.8491
13	Idaho	26.1426	25.4397
14	Illinois	29.2557	28.1409
15	Indiana	29.3235	28.4347
16	Iowa	29.8030	28.9280
17	Kansas	27.8665	27.0309
18	Kentucky	27.6898	26.5212
19	Louisiana	27.7399	26.2678
20	Maine	29.9878	28.8613
21	Maryland	32.4848	30.6740
22	Massachusetts[1]	----	----
23	Michigan	30.0405	29.4059
24	Minnesota	31.6251	30.5376
25	Mississippi	27.0138	25.8819
26	Missouri	27.2630	26.6216
27	Montana	29.4658	28.4050
28	Nebraska	31.0214	29.3825
29	Nevada	32.7810	32.3514
30	New Hampshire	34.6904	33.8700
31	New Jersey[2]	----	----
32	New Mexico	31.5263	30.1115
33	New York	29.0517	27.9458
34	North Carolina	29.5268	28.7455
35	North Dakota	24.5023	24.8120
36	Ohio	29.9108	28.7616
37	Oklahoma	28.0420	26.6656
38	Oregon	34.9774	34.1391
39	Pennsylvania	29.7971	28.2813
40	Puerto Rico[2]	----	----
41	Rhode Island[2]	----	----
42	South Carolina	29.4603	28.4856
43	South Dakota	29.3712	28.1981
44	Tennessee	27.8764	26.6861
45	Texas	27.9871	26.9747
46	Utah	30.4214	28.6155
47	Vermont	33.0189	32.4250
49	Virginia	28.1471	27.0795
50	Washington	35.3253	34.0250
51	West Virginia	26.4462	25.3997
52	Wisconsin	31.4858	30.9851
53	Wyoming	32.7909	31.3477

[1]Massachusetts has area(s) designated as rural. However, no short term, acute care hospitals are located in the area(s) for FY 2011.
[2]All counties within the State or territory are classified as urban.

TABLE 4A.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA AND BY STATE--FY 2011

[Constituent counties are listed in Table 4E.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
10180	Abilene, TX	TX	0.8416	0.8886
10380	Aguadilla-Isabela-San Sebastián, PR	PR	0.3384	0.4762
10420	Akron, OH	OH	0.8850	0.9197
10500	Albany, GA	GA	0.9098	0.9373
10580	Albany-Schenectady-Troy, NY	NY	0.8708	0.9096
10740	Albuquerque, NM	NM	0.9638	0.9751
10780	Alexandria, LA	LA	0.8164	0.8703
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1069	1.0720
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9418	0.9598
11020	Altoona, PA	PA	0.8529	0.8968
11100	Amarillo, TX	TX	0.8574	0.9000
11180	Ames, IA	IA	1.0044	1.0030
11260	Anchorage, AK	AK	1.1919	1.1277
11300	Anderson, IN	IN	0.9287	0.9506
11340	Anderson, SC	SC	0.8438	0.8902
11460	Ann Arbor, MI	MI	1.0107	1.0073
11500	Anniston-Oxford, AL	AL	0.7898	0.8508
11540	Appleton, WI	WI	0.9348	0.9549
11700	Asheville, NC	NC	0.9055	0.9343
12020	Athens-Clarke County, GA	GA	0.9348	0.9549
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9572	0.9705
12100	Atlantic City-Hammonton, NJ	NJ	1.1069	1.0720
12220	Auburn-Opelika, AL	AL	0.7522	0.8228
12260	Augusta-Richmond County, GA-SC	GA	0.9571	0.9704
12260	Augusta-Richmond County, GA-SC	SC	0.9571	0.9704
12420	Austin-Round Rock-San Marcos, TX	TX	0.9523	0.9671
12540	Bakersfield-Delano, CA	CA	1.2002	1.1331
12580	Baltimore-Towson, MD	MD	1.0198	1.0135
12620	Bangor, ME	ME	0.9695	0.9790
12700	Barnstable Town, MA	MA	1.2825	1.1858
12940	Baton Rouge, LA	LA	0.8726	0.9109
12980	Battle Creek, MI	MI	0.9759	0.9834
13020	Bay City, MI	MI	0.9429	0.9605
13140	Beaumont-Port Arthur, TX	TX	0.8456	0.8915
13380	Bellingham, WA	WA	1.1302	1.0874
13460	Bend, OR	OR	1.1239	1.0833
13644	Bethesda-Rockville-Frederick, MD	MD	1.0573	1.0389
13740	Billings, MT	MT	0.8944	0.9264
13780	Binghamton, NY	NY	0.8932	0.9256
13820	Birmingham-Hoover, AL	AL	0.8614	0.9029
13900	Bismarck, ND	ND	0.7641	0.8317
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8293	0.8797
14020	Bloomington, IN	IN	0.9287	0.9506
14060	Bloomington-Normal, IL	IL	0.9567	0.9701
14260	Boise City-Nampa, ID	ID	0.9305	0.9519
14484	Boston-Quincy, MA	MA	1.2342	1.1550
14500	Boulder, CO	CO	0.9983	0.9988
14540	Bowling Green, KY	KY	0.8722	0.9106
14740	Bremerton-Silverdale, WA	WA	1.0580	1.0394
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2575	1.1699
15180	Brownsville-Harlingen, TX	TX	0.9486	0.9645
15260	Brunswick, GA	GA	0.9352	0.9552
15380	Buffalo-Niagara Falls, NY	NY	0.9628	0.9744
15500	Burlington, NC	NC	0.8787	0.9153
15540	Burlington-South Burlington, VT	VT	1.0340	1.0232
15764	Cambridge-Newton-Framingham, MA	MA	1.1294	1.0869
15804	Camden, NJ	NJ	1.1069	1.0720
15940	Canton-Massillon, OH	OH	0.8612	0.9027
15980	Cape Coral-Fort Myers, FL	FL	0.9167	0.9422
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8810	0.9169
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8810	0.9169
16180	Carson City, NV	NV	1.0282	1.0192
16220	Casper, WY	WY	0.9444	0.9616
16300	Cedar Rapids, IA	IA	0.8799	0.9161
16580	Champaign-Urbana, IL	IL	1.0161	1.0110
16620	Charleston, WV	WV	0.8093	0.8651
16700	Charleston-North Charleston-Summerville, SC	SC	0.9295	0.9512
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9299	0.9514
16740	Charlotte-Gastonia-Rock Hill, NC-SC	SC	0.9300	0.9515
16820	Charlottesville, VA	VA	0.9243	0.9475
16860	Chattanooga, TN-GA	GA	0.8794	0.9158
16860	Chattanooga, TN-GA	TN	0.8721	0.9105
16940	Cheyenne, WY	WY	0.9392	0.9580
16974	Chicago-Joliet-Naperville, IL	IL	1.0503	1.0342
17020	Chico, CA	CA	1.2002	1.1331
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9637	0.9750
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9634	0.9748
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9624	0.9741

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
17300	Clarksville, TN-KY	KY	0.7992	0.8577
17300	Clarksville, TN-KY	TN	0.7919	0.8523
17420	Cleveland, TN	TN	0.7919	0.8523
17460	Cleveland-Elyria-Mentor, OH	OH	0.9082	0.9362
17660	Coeur d'Alene, ID	ID	0.9216	0.9456
17780	College Station-Bryan, TX	TX	0.9244	0.9476
17820	Colorado Springs, CO	CO	0.9581	0.9711
17860	Columbia, MO	MO	0.8261	0.8774
17900	Columbia, SC	SC	0.8799	0.9161
17980	Columbus, GA-AL	AL	0.9111	0.9382
17980	Columbus, GA-AL	GA	0.9119	0.9388
18020	Columbus, IN	IN	0.9476	0.9638
18140	Columbus, OH	OH	1.0163	1.0111
18580	Corpus Christi, TX	TX	0.8576	0.9001
18700	Corvallis, OR	OR	1.0340	1.0232
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8762	0.9135
19060	Cumberland, MD-WV	MD	0.9305	0.9519
19060	Cumberland, MD-WV	WV	0.8196	0.8726
19124	Dallas-Plano-Irving, TX	TX	0.9734	0.9817
19140	Dalton, GA	GA	0.8483	0.8935
19180	Danville, IL	IL	0.9722	0.9809
19260	Danville, VA	VA	0.8168	0.8706
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8658	0.9060
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8654	0.9057
19380	Dayton, OH	OH	0.9172	0.9425
19460	Decatur, AL	AL	0.7583	0.8274
19500	Decatur, IL	IL	0.8380	0.8860
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8773	0.9143
19740	Denver-Aurora-Broomfield, CO	CO	1.0485	1.0330
19780	Des Moines-West Des Moines, IA	IA	0.9525	0.9672
19804	Detroit-Livonia-Dearborn, MI	MI	0.9776	0.9846
20020	Dothan, AL	AL	0.7743	0.8393
20100	Dover, DE	DE	1.0090	1.0062
20220	Dubuque, IA	IA	0.8562	0.8991
20260	Duluth, MN-WI	MN	1.0682	1.0462
20260	Duluth, MN-WI	WI	1.0682	1.0462
20500	Durham-Chapel Hill, NC	NC	0.9662	0.9767
20740	Eau Claire, WI	WI	0.9600	0.9724
20764	Edison-New Brunswick, NJ	NJ	1.1069	1.0720
20940	El Centro, CA	CA	1.2002	1.1331
21060	Elizabethtown, KY	KY	0.8389	0.8867
21140	Elkhart-Goshen, IN	IN	0.9457	0.9625

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
21300	Elmira, NY	NY	0.8540	0.8976
21340	El Paso, TX	TX	0.8594	0.9014
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.1331	1.0893
21780	Evansville, IN-KY	IN	0.8399	0.8874
21780	Evansville, IN-KY	KY	0.8393	0.8869
21820	Fairbanks, AK	AK	1.1919	1.1277
21940	Fajardo, PR	PR	0.3892	0.5240
22020	Fargo, ND-MN	MN	0.9146	0.9407
22020	Fargo, ND-MN	ND	0.8102	0.8658
22140	Farmington, NM	NM	0.9030	0.9325
22180	Fayetteville, NC	NC	0.9453	0.9622
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8648	0.9053
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.8648	0.9053
22380	Flagstaff, AZ	AZ	1.2457	1.1624
22420	Flint, MI	MI	1.1382	1.0927
22500	Florence, SC	SC	0.8478	0.8931
22520	Florence-Muscle Shoals, AL	AL	0.8028	0.8603
22540	Fond du Lac, WI	WI	0.9386	0.9575
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0364	1.0248
22900	Fort Smith, AR-OK	AR	0.7742	0.8392
22900	Fort Smith, AR-OK	OK	0.8052	0.8621
23060	Fort Wayne, IN	IN	0.9245	0.9477
23104	Fort Worth-Arlington, TX	TX	0.9427	0.9604
23420	Fresno, CA	CA	1.2002	1.1331
23460	Gadsden, AL	AL	0.7448	0.8173
23540	Gainesville, FL	FL	0.9406	0.9589
23580	Gainesville, GA	GA	0.9709	0.9800
23844	Gary, IN	IN	0.9069	0.9353
24020	Glens Falls, NY	NY	0.8828	0.9182
24140	Goldsboro, NC	NC	0.9280	0.9501
24220	Grand Forks, ND-MN	MN	0.9146	0.9407
24220	Grand Forks, ND-MN	ND	0.8034	0.8608
24300	Grand Junction, CO	CO	1.0051	1.0035
24340	Grand Rapids-Wyoming, MI	MI	0.9315	0.9526
24500	Great Falls, MT	MT	0.8439	0.8903
24540	Greeley, CO	CO	0.9581	0.9711
24580	Green Bay, WI	WI	0.9443	0.9615
24660	Greensboro-High Point, NC	NC	0.8996	0.9301
24780	Greenville, NC	NC	0.9343	0.9545

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
24860	Greenville-Mauldin-Easley, SC	SC	0.9357	0.9555
25020	Guayama, PR	PR	0.3577	0.4946
25060	Gulfport-Biloxi, MS	MS	0.8923	0.9249
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9505	0.9658
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9455	0.9623
25260	Hanford-Corcoran, CA	CA	1.2002	1.1331
25420	Harrisburg-Carlisle, PA	PA	0.9172	0.9425
25500	Harrisonburg, VA	VA	0.9294	0.9511
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251	1.0841
25620	Hattiesburg, MS	MS	0.7950	0.8546
25860	Hickory-Lenoir-Morganton, NC	NC	0.8650	0.9055
26100	Holland-Grand Haven, MI	MI	0.8796	0.9159
26180	Honolulu, HI	HI	1.1635	1.1093
26300	Hot Springs, AR	AR	0.9296	0.9512
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.7992	0.8577
26420	Houston-Sugar Land-Baytown, TX	TX	0.9946	0.9963
26580	Huntington-Ashland, WV-KY-OH	KY	0.8919	0.9246
26580	Huntington-Ashland, WV-KY-OH	OH	0.8909	0.9239
26580	Huntington-Ashland, WV-KY-OH	WV	0.8875	0.9215
26620	Huntsville, AL	AL	0.8994	0.9300
26820	Idaho Falls, ID	ID	0.9676	0.9777
26900	Indianapolis-Carmel, IN	IN	0.9555	0.9693
26980	Iowa City, IA	IA	0.9550	0.9690
27060	Ithaca, NY	NY	0.9777	0.9847
27100	Jackson, MI	MI	0.9260	0.9487
27140	Jackson, MS	MS	0.8125	0.8675
27180	Jackson, TN	TN	0.8310	0.8809
27260	Jacksonville, FL	FL	0.8902	0.9234
27340	Jacksonville, NC	NC	0.8476	0.8929
27500	Janesville, WI	WI	0.9694	0.9789
27620	Jefferson City, MO	MO	0.8605	0.9022
27740	Johnson City, TN	TN	0.7919	0.8523
27780	Johnstown, PA	PA	0.8521	0.8962
27860	Jonesboro, AR	AR	0.7833	0.8460
27900	Joplin, MO	MO	0.8448	0.8909
28020	Kalamazoo-Portage, MI	MI	1.0313	1.0213
28100	Kankakee-Bradley, IL	IL	1.0571	1.0388
28140	Kansas City, MO-KS	KS	0.9558	0.9695
28140	Kansas City, MO-KS	MO	0.9558	0.9695
28420	Kennewick-Pasco-Richland, WA	WA	1.0107	1.0073
28660	Killeen-Temple-Fort Hood, TX	TX	0.8775	0.9144
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919	0.8523
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8060	0.8627
28740	Kingston, NY	NY	0.9152	0.9411
28940	Knoxville, TN	TN	0.7919	0.8523
29020	Kokomo, IN	IN	0.9010	0.9311
29100	La Crosse, WI-MN	MN	0.9864	0.9907
29100	La Crosse, WI-MN	WI	0.9864	0.9907
29140	Lafayette, IN	IN	0.9253	0.9482
29180	Lafayette, LA	LA	0.8473	0.8927
29340	Lake Charles, LA	LA	0.8202	0.8731
29404	Lake County-Kenosha County, IL-WI	IL	1.0736	1.0498
29404	Lake County-Kenosha County, IL-WI	WI	1.0736	1.0498
29420	Lake Havasu City-Kingman, AZ	AZ	1.0287	1.0196
29460	Lakeland-Winter Haven, FL	FL	0.8628	0.9039
29540	Lancaster, PA	PA	0.9760	0.9835
29620	Lansing-East Lansing, MI	MI	1.0269	1.0183
29700	Laredo, TX	TX	0.8312	0.8811
29740	Las Cruces, NM	NM	0.9183	0.9433
29820	Las Vegas-Paradise, NV	NV	1.1811	1.1207
29940	Lawrence, KS	KS	0.8513	0.8956
30020	Lawton, OK	OK	0.8616	0.9030
30140	Lebanon, PA	PA	0.8521	0.8962
30300	Lewiston, ID-WA	ID	0.9180	0.9431
30300	Lewiston, ID-WA	WA	1.0107	1.0073
30340	Lewiston-Auburn, ME	ME	0.8956	0.9273
30460	Lexington-Fayette, KY	KY	0.8798	0.9160
30620	Lima, OH	OH	0.9254	0.9483
30700	Lincoln, NE	NE	0.9490	0.9648
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8675	0.9072
30860	Logan, UT-ID	ID	0.8843	0.9192
30860	Logan, UT-ID	UT	0.8843	0.9192
30980	Longview, TX	TX	0.8593	0.9014
31020	Longview, WA	WA	1.0667	1.0452
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002	1.1331
31140	Louisville-Jefferson County, KY-IN	IN	0.8850	0.9197
31140	Louisville-Jefferson County, KY-IN	KY	0.8848	0.9196
31180	Lubbock, TX	TX	0.8940	0.9261
31340	Lynchburg, VA	VA	0.8527	0.8966
31420	Macon, GA	GA	0.9368	0.9563
31460	Madera-Chowchilla, CA	CA	1.2002	1.1331
31540	Madison, WI	WI	1.1316	1.0884
31700	Manchester-Nashua, NH	NH	1.0054	1.0037
31740	Manhattan, KS	KS	0.8027	0.8603

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
31860	Mankato-North Mankato, MN	MN	0.9270	0.9494
31900	Mansfield, OH	OH	0.8917	0.9245
32420	Mayagüez, PR	PR	0.3612	0.4979
32580	McAllen-Edinburg-Mission, TX	TX	0.8888	0.9224
32780	Medford, OR	OR	1.0089	1.0061
32820	Memphis, TN-MS-AR	AR	0.9213	0.9454
32820	Memphis, TN-MS-AR	MS	0.9213	0.9454
32820	Memphis, TN-MS-AR	TN	0.9137	0.9401
32900	Merced, CA	CA	1.2002	1.1331
33124	Miami-Miami Beach-Kendall, FL	FL	1.0222	1.0151
33140	Michigan City-La Porte, IN	IN	0.9399	0.9584
33260	Midland, TX	TX	0.9554	0.9692
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0226	1.0154
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.1027	1.0692
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.1027	1.0692
33540	Missoula, MT	MT	0.8811	0.9170
33660	Mobile, AL	AL	0.7899	0.8509
33700	Modesto, CA	CA	1.2002	1.1331
33740	Monroe, LA	LA	0.8122	0.8672
33780	Monroe, MI	MI	0.9666	0.9770
33860	Montgomery, AL	AL	0.8506	0.8951
34060	Morgantown, WV	WV	0.8266	0.8777
34100	Morristown, TN	TN	0.7919	0.8523
34580	Mount Vernon-Anacortes, WA	WA	1.0107	1.0073
34620	Muncie, IN	IN	0.8399	0.8874
34740	Muskegon-Norton Shores, MI	MI	0.9829	0.9883
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8681	0.9077
34900	Napa, CA	CA	1.4144	1.2680
34940	Naples-Marco Island, FL	FL	0.9809	0.9869
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9246	0.9477
35004	Nassau-Suffolk, NY	NY	1.2591	1.1709
35084	Newark-Union, NJ-PA	NJ	1.1099	1.0740
35084	Newark-Union, NJ-PA	PA	1.1296	1.0870
35300	New Haven-Milford, CT	CT	1.1654	1.1105
35380	New Orleans-Metairie-Kenner, LA	LA	0.9005	0.9307
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2884	1.1895
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3154	1.2065
35660	Niles-Benton Harbor, MI	MI	0.8990	0.9297
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9265	0.9491
35980	Norwich-New London, CT	CT	1.1353	1.0908
36084	Oakland-Fremont-Hayward, CA	CA	1.5536	1.3522
36100	Ocala, FL	FL	0.8578	0.9003

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
36140	Ocean City, NJ	NJ	1.1069	1.0720
36220	Odessa, TX	TX	0.9426	0.9603
36260	Ogden-Clearfield, UT	UT	0.9354	0.9553
36420	Oklahoma City, OK	OK	0.8900	0.9233
36500	Olympia, WA	WA	1.1015	1.0684
36540	Omaha-Council Bluffs, NE-IA	IA	0.9550	0.9690
36540	Omaha-Council Bluffs, NE-IA	NE	0.9554	0.9692
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9178	0.9430
36780	Oshkosh-Neenah, WI	WI	0.9514	0.9665
36980	Owensboro, KY	KY	0.8532	0.8970
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.2078	1.1380
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9332	0.9538
37380	Palm Coast, FL	FL	0.8458	0.8916
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8458	0.8916
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8555	0.8986
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7536	0.8239
37700	Pascagoula, MS	MS	0.8182	0.8716
37764	Peabody, MA	MA	1.1021	1.0688
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8458	0.8916
37900	Peoria, IL	IL	0.9289	0.9507
37964	Philadelphia, PA	PA	1.0780	1.0528
38060	Phoenix-Mesa-Glendale, AZ	AZ	1.0519	1.0353
38220	Pine Bluff, AR	AR	0.8311	0.8810
38300	Pittsburgh, PA	PA	0.8579	0.9004
38340	Pittsfield, MA	MA	1.0483	1.0328
38540	Pocatello, ID	ID	0.9379	0.9570
38660	Ponce, PR	PR	0.4278	0.5591
38860	Portland-South Portland-Biddeford, ME	ME	0.9930	0.9952
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1221	1.0821
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1212	1.0815
38940	Port St. Lucie, FL	FL	1.0762	1.0516
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1418	1.0951
39140	Prescott, AZ	AZ	1.2318	1.1535
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0751	1.0508
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0751	1.0508
39340	Provo-Orem, UT	UT	0.9272	0.9496
39380	Pueblo, CO	CO	0.9581	0.9711
39460	Punta Gorda, FL	FL	0.9070	0.9353
39540	Racine, WI	WI	1.0651	1.0441
39580	Raleigh-Cary, NC	NC	0.9713	0.9803
39660	Rapid City, SD	SD	1.0990	1.0668
39740	Reading, PA	PA	0.8856	0.9202

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
39820	Redding, CA	CA	1.3277	1.2142
39900	Reno-Sparks, NV	NV	1.0439	1.0299
40060	Richmond, VA	VA	0.9536	0.9680
40140	Riverside-San Bernardino-Ontario, CA	CA	1.2002	1.1331
40220	Roanoke, VA	VA	0.9020	0.9318
40340	Rochester, MN	MN	1.0759	1.0514
40380	Rochester, NY	NY	0.8708	0.9096
40420	Rockford, IL	IL	1.0052	1.0036
40484	Rockingham County-Strafford County, NH	NH	1.0218	1.0149
40580	Rocky Mount, NC	NC	0.9123	0.9391
40660	Rome, GA	GA	0.8760	0.9133
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3217	1.2105
40980	Saginaw-Saginaw Township North, MI	MI	0.9210	0.9452
41060	St. Cloud, MN	MN	1.1654	1.1105
41100	St. George, UT	UT	0.9311	0.9523
41140	St. Joseph, MO-KS	KS	1.0377	1.0257
41140	St. Joseph, MO-KS	MO	1.0377	1.0257
41180	St. Louis, MO-IL	IL	0.9060	0.9346
41180	St. Louis, MO-IL	MO	0.9060	0.9346
41420	Salem, OR	OR	1.1119	1.0753
41500	Salinas, CA	CA	1.5512	1.3507
41540	Salisbury, MD	MD	0.9305	0.9519
41620	Salt Lake City, UT	UT	0.9362	0.9559
41660	San Angelo, TX	TX	0.8479	0.8932
41700	San Antonio-New Braunfels, TX	TX	0.9071	0.9354
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.2002	1.1331
41780	Sandusky, OH	OH	0.8610	0.9026
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5036	1.3222
41900	San Germán-Cabo Rojo, PR	PR	0.4570	0.5849
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6044	1.3823
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4302	0.5612
42020	San Luis Obispo-Paso Robles, CA	CA	1.2121	1.1408
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002	1.1331
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.2002	1.1331
42100	Santa Cruz-Watsonville, CA	CA	1.6059	1.3832
42140	Santa Fe, NM	NM	1.0788	1.0533
42220	Santa Rosa-Petaluma, CA	CA	1.5455	1.3473
42340	Savannah, GA	GA	0.8858	0.9203
42540	Scranton--Wilkes-Barre, PA	PA	0.8521	0.8962
42644	Seattle-Bellevue-Everett, WA	WA	1.1393	1.0934
42680	Sebastian-Vero Beach, FL	FL	0.9276	0.9498
43100	Sheboygan, WI	WI	0.9299	0.9514

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
43300	Sherman-Denison, TX	TX	0.8443	0.8906
43340	Shreveport-Bossier City, LA	LA	0.8651	0.9055
43580	Sioux City, IA-NE-SD	IA	0.8964	0.9278
43580	Sioux City, IA-NE-SD	NE	0.8968	0.9281
43580	Sioux City, IA-NE-SD	SD	0.8968	0.9281
43620	Sioux Falls, SD	SD	0.9388	0.9577
43780	South Bend-Mishawaka, IN-MI	IN	0.9889	0.9924
43780	South Bend-Mishawaka, IN-MI	MI	0.9889	0.9924
43900	Spartanburg, SC	SC	0.9086	0.9365
44060	Spokane, WA	WA	1.0588	1.0399
44100	Springfield, IL	IL	0.8948	0.9267
44140	Springfield, MA	MA	1.0361	1.0246
44180	Springfield, MO	MO	0.8413	0.8884
44220	Springfield, OH	OH	0.8997	0.9302
44300	State College, PA	PA	0.8640	0.9047
44600	Steubenville-Weirton, OH-WV	OH	0.8555	0.8986
44600	Steubenville-Weirton, OH-WV	WV	0.7536	0.8239
44700	Stockton, CA	CA	1.2252	1.1492
44940	Sumter, SC	SC	0.8438	0.8902
45060	Syracuse, NY	NY	0.9710	0.9800
45104	Tacoma, WA	WA	1.1264	1.0849
45220	Tallahassee, FL	FL	0.8981	0.9290
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9094	0.9370
45460	Terre Haute, IN	IN	0.9254	0.9483
45500	Texarkana, TX-Texarkana, AR	AR	0.7703	0.8363
45500	Texarkana, TX-Texarkana, AR	TX	0.8018	0.8596
45780	Toledo, OH	OH	0.9374	0.9567
45820	Topeka, KS	KS	0.9138	0.9401
45940	Trenton-Ewing, NJ	NJ	1.1069	1.0720
46060	Tucson, AZ	AZ	0.9692	0.9788
46140	Tulsa, OK	OK	0.8903	0.9235
46220	Tuscaloosa, AL	AL	0.8225	0.8748
46340	Tyler, TX	TX	0.8259	0.8772
46540	Utica-Rome, NY	NY	0.8737	0.9117
46660	Valdosta, GA	GA	0.8131	0.8679
46700	Vallejo-Fairfield, CA	CA	1.4207	1.2718
47020	Victoria, TX	TX	0.8038	0.8611
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1069	1.0720
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8954	0.9271
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8953	0.9271
47300	Visalia-Porterville, CA	CA	1.2002	1.1331
47380	Waco, TX	TX	0.8648	0.9053

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
47580	Warner Robins, GA	GA	0.8470	0.8925
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9725	0.9811
47894	Washington-Arlington-Alexandria, DC-VA	DC	1.0561	1.0381
47894	Washington-Arlington-Alexandria, DC-VA	MD	1.0561	1.0381
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0559	1.0380
47894	Washington-Arlington-Alexandria, DC-VA	WV	1.0506	1.0344
47940	Waterloo-Cedar Falls, IA	IA	0.8533	0.8971
48140	Wausau, WI	WI	0.9581	0.9711
48300	Wenatchee-East Wenatchee, WA	WA	1.0107	1.0073
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9824	0.9879
48540	Wheeling, WV-OH	OH	0.8555	0.8986
48540	Wheeling, WV-OH	WV	0.7536	0.8239
48620	Wichita, KS	KS	0.8860	0.9205
48660	Wichita Falls, TX	TX	0.9929	0.9951
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0802	1.0543
48864	Wilmington, DE-MD-NJ	MD	1.0802	1.0543
48864	Wilmington, DE-MD-NJ	NJ	1.1069	1.0720
48900	Wilmington, NC	NC	0.9264	0.9490
49020	Winchester, VA-WV	VA	0.9996	0.9997
49020	Winchester, VA-WV	WV	0.9946	0.9963
49180	Winston-Salem, NC	NC	0.8974	0.9285
49340	Worcester, MA	MA	1.1210	1.0814
49420	Yakima, WA	WA	1.0107	1.0073
49500	Yauco, PR	PR	0.3544	0.4915
49620	York-Hanover, PA	PA	0.9539	0.9682
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8628	0.9039
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8612	0.9027
49700	Yuba City, CA	CA	1.2002	1.1331
49740	Yuma, AZ	AZ	0.9455	0.9623

TABLE 4B.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN RURAL AREAS BY CBSA AND BY STATE--FY 2011

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Rural Area	State	Proposed Wage Index	Proposed GAF
01	Alabama	AL	0.7448	0.8173
02	Alaska	AK	1.1919	1.1277
03	Arizona	AZ	0.9120	0.9389
04	Arkansas	AR	0.7517	0.8225
05	California	CA	1.2002	1.1331
06	Colorado	CO	0.9581	0.9711
07	Connecticut	CT	1.1251	1.0841
08	Delaware	DE	1.0090	1.0062
10	Florida	FL	0.8458	0.8916
11	Georgia	GA	0.7782	0.8422
12	Hawaii	HI	1.1292	1.0868
13	Idaho	ID	0.7587	0.8277
14	Illinois	IL	0.8380	0.8860
15	Indiana	IN	0.8399	0.8874
16	Iowa	IA	0.8533	0.8971
17	Kansas	KS	0.8027	0.8603
18	Kentucky	KY	0.7992	0.8577
19	Louisiana	LA	0.7946	0.8543
20	Maine	ME	0.8589	0.9011
21	Maryland	MD	0.9305	0.9519
22	Massachusetts	MA	0.9671	0.9774
23	Michigan	MI	0.8605	0.9022
24	Minnesota	MN	0.9146	0.9407
25	Mississippi	MS	0.7738	0.8389
26	Missouri	MO	0.8127	0.8676
27	Montana	MT	0.8439	0.8903
28	Nebraska	NE	0.8886	0.9223
29	Nevada	NV	0.9555	0.9693
30	New Hampshire	NH	1.0054	1.0037
31	New Jersey[1]	NJ	1.1069	1.0720
32	New Mexico	NM	0.9030	0.9325
33	New York	NY	0.8420	0.8889
34	North Carolina	NC	0.8476	0.8929
35	North Dakota	ND	0.7018	0.7847
36	Ohio	OH	0.8555	0.8986
37	Oklahoma	OK	0.8052	0.8621

CBSA Code	Rural Area	State	Proposed Wage Index	Proposed GAF
38	Oregon	OR	1.0089	1.0061
39	Pennsylvania	PA	0.8521	0.8962
40	Puerto Rico[1]	PR	------	------
41	Rhode Island[1]	RI	------	------
42	South Carolina	SC	0.8438	0.8902
43	South Dakota	SD	0.8435	0.8900
44	Tennessee	TN	0.7919	0.8523
45	Texas	TX	0.8018	0.8596
46	Utah	UT	0.8714	0.9100
47	Vermont	VT	0.9465	0.9630
49	Virginia	VA	0.8060	0.8627
50	Washington	WA	1.0107	1.0073
51	West Virginia	WV	0.7536	0.8239
52	Wisconsin	WI	0.9019	0.9317
53	Wyoming	WY	0.9392	0.9580

[1] All counties in the State or Territory are classified as urban. The New Jersey floor is imputed as specified in §412.64 (h)(4) and discussed in the FY 2005 IPPS final rule (69 FR 49109) and in section III.B.2. of the preamble of the FY 2009 IPPS final rule (73 FR 48567).

TABLE 4C.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE--FY 2011

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
04	Arkansas	AR	0.7517	0.8225
05	California	CA	1.2002	1.1331
07	Connecticut	CT	1.1251	1.0841
10	Florida	FL	0.8458	0.8916
14	Illinois	IL	0.8380	0.8860
14	Illinois	MO	0.8380	0.8860
17	Kansas	KS	0.8027	0.8603
18	Kentucky	KY	0.7992	0.8577
22	Massachusetts	MA	0.9671	0.9774
23	Michigan	MI	0.8605	0.9022
24	Minnesota	IA	0.9142	0.9404
26	Missouri	AR	0.8127	0.8676
26	Missouri	MO	0.8127	0.8676
28	Nebraska	KS	0.8886	0.9223
33	New York	NH	1.0054	1.0037
33	New York	NY	0.8420	0.8889
34	North Carolina	NC	0.8476	0.8929
34	North Carolina	TN	0.8407	0.8880
36	Ohio	OH	0.8555	0.8986
37	Oklahoma	OK	0.8052	0.8621
38	Oregon	OR	1.0089	1.0061
39	Pennsylvania	PA	0.8521	0.8962
44	Tennessee	KY	0.7992	0.8577
45	Texas	LA	0.8022	0.8599
45	Texas	OK	0.8052	0.8621
45	Texas	TX	0.8018	0.8596
47	Vermont	NY	0.9328	0.9535
49	Virginia	KY	0.8060	0.8627
49	Virginia	VA	0.8060	0.8627
49	Virginia	WV	0.8020	0.8598
50	Washington	WA	1.0107	1.0073
10500	Albany, GA	AL	0.8539	0.8975
10500	Albany, GA	GA	0.8547	0.8981
10580	Albany-Schenectady-Troy, NY	NY	0.8708	0.9096
10740	Albuquerque, NM	NM	0.9505	0.9658
10780	Alexandria, LA	LA	0.8164	0.8703
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9418	0.9598
11100	Amarillo, TX	KS	0.8438	0.8902
11100	Amarillo, TX	TX	0.8434	0.8899
11180	Ames, IA	IA	0.9273	0.9496
11260	Anchorage, AK	AK	1.1919	1.1277
11300	Anderson, IN	IN	0.8736	0.9116
11460	Ann Arbor, MI	MI	0.9849	0.9896
12020	Athens-Clarke County, GA	GA	0.9348	0.9549
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9563	0.9699
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9572	0.9705
12260	Augusta-Richmond County, GA-SC	SC	0.9571	0.9704
12420	Austin-Round Rock-San Marcos, TX	TX	0.9523	0.9671
12620	Bangor, ME	ME	0.9695	0.9790
12940	Baton Rouge, LA	MS	0.8580	0.9004
12980	Battle Creek, MI	MI	0.9759	0.9834
13020	Bay City, MI	MI	0.8891	0.9227
13644	Bethesda-Rockville-Frederick, MD	DC	1.0573	1.0389
13644	Bethesda-Rockville-Frederick, MD	PA	1.0539	1.0366
13644	Bethesda-Rockville-Frederick, MD	VA	1.0571	1.0388

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
13780	Binghamton, NY	PA	0.8762	0.9135
13820	Birmingham-Hoover, AL	AL	0.8427	0.8894
13900	Bismarck, ND	ND	0.7451	0.8175
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7746	0.8395
14260	Boise City-Nampa, ID	ID	0.9068	0.9352
14484	Boston-Quincy, MA	MA	1.1613	1.1078
14484	Boston-Quincy, MA	RI	1.1613	1.1078
14540	Bowling Green, KY	KY	0.8347	0.8836
14740	Bremerton-Silverdale, WA	WA	1.0399	1.0272
15260	Brunswick, GA	GA	0.9352	0.9552
15380	Buffalo-Niagara Falls, NY	NY	0.9628	0.9744
15540	Burlington-South Burlington, VT	NY	1.0071	1.0049
15540	Burlington-South Burlington, VT	VT	1.0071	1.0049
15764	Cambridge-Newton-Framingham, MA	NH	1.0990	1.0668
15940	Canton-Massillon, OH	OH	0.8612	0.9027
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8380	0.8860
16020	Cape Girardeau-Jackson, MO-IL	KY	0.8361	0.8846
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8363	0.8848
16180	Carson City, NV	NV	0.9960	0.9973
16580	Champaign-Urbana, IL	IL	0.9154	0.9413
16620	Charleston, WV	WV	0.8093	0.8651
16700	Charleston-North Charleston-Summerville, SC	SC	0.9295	0.9512
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9162	0.9418
16820	Charlottesville, VA	VA	0.9243	0.9475
16860	Chattanooga, TN-GA	AL	0.8594	0.9014
16860	Chattanooga, TN-GA	GA	0.8602	0.9020
16860	Chattanooga, TN-GA	TN	0.8531	0.8969
16974	Chicago-Joliet-Naperville, IL	IL	1.0370	1.0252
16974	Chicago-Joliet-Naperville, IL	IN	1.0370	1.0252
16974	Chicago-Joliet-Naperville, IL	WI	1.0370	1.0252
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9637	0.9750
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9634	0.9748
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9624	0.9741
17300	Clarksville, TN-KY	KY	0.7992	0.8577
17460	Cleveland-Elyria-Mentor, OH	OH	0.9082	0.9362
17780	College Station-Bryan, TX	TX	0.9244	0.9476
17860	Columbia, MO	MO	0.8261	0.8774
17900	Columbia, SC	SC	0.8695	0.9087
17980	Columbus, GA-AL	AL	0.8613	0.9028
17980	Columbus, GA-AL	GA	0.8621	0.9034
18140	Columbus, OH	OH	1.0025	1.0017
18580	Corpus Christi, TX	TX	0.8576	0.9001

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
18700	Corvallis, OR	OR	1.0149	1.0102
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8565	0.8994
19124	Dallas-Plano-Irving, TX	TX	0.9584	0.9713
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8658	0.9060
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8654	0.9057
19380	Dayton, OH	OH	0.9172	0.9425
19460	Decatur, AL	AL	0.7583	0.8274
19740	Denver-Aurora-Broomfield, CO	CO	1.0303	1.0207
19780	Des Moines-West Des Moines, IA	IA	0.9525	0.9672
19804	Detroit-Livonia-Dearborn, MI	MI	0.9776	0.9846
20100	Dover, DE	DE	1.0090	1.0062
20500	Durham-Chapel Hill, NC	NC	0.9662	0.9767
20500	Durham-Chapel Hill, NC	VA	0.9661	0.9767
20764	Edison-New Brunswick, NJ	NJ	1.1069	1.0720
21060	Elizabethtown, KY	KY	0.8389	0.8867
21140	Elkhart-Goshen, IN	IN	0.9457	0.9625
21500	Erie, PA	NY	0.8420	0.8889
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.1032	1.0696
22180	Fayetteville, NC	NC	0.9238	0.9472
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8646	0.9052
22420	Flint, MI	MI	1.0134	1.0092
22520	Florence-Muscle Shoals, AL	MS	0.8035	0.8609
22540	Fond du Lac, WI	WI	0.9178	0.9430
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0364	1.0248
23060	Fort Wayne, IN	IN	0.9245	0.9477
23104	Fort Worth-Arlington, TX	TX	0.9427	0.9604
23540	Gainesville, FL	FL	0.9406	0.9589
23844	Gary, IN	IN	0.9069	0.9353
24300	Grand Junction, CO	CO	1.0051	1.0035
24340	Grand Rapids-Wyoming, MI	MI	0.9315	0.9526
24500	Great Falls, MT	MT	0.8439	0.8903
24540	Greeley, CO	NE	0.9418	0.9598
24540	Greeley, CO	WY	0.9418	0.9598
24580	Green Bay, WI	MI	0.9249	0.9479
24580	Green Bay, WI	WI	0.9249	0.9479
24660	Greensboro-High Point, NC	NC	0.8996	0.9301
24780	Greenville, NC	NC	0.9192	0.9439
24860	Greenville-Mauldin-Easley, SC	NC	0.9127	0.9394
24860	Greenville-Mauldin-Easley, SC	SC	0.9128	0.9394

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
25060	Gulfport-Biloxi, MS	MS	0.8350	0.8838
25420	Harrisburg-Carlisle, PA	PA	0.9172	0.9425
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251	1.0841
25540	Hartford-West Hartford-East Hartford, CT	MA	1.1117	1.0752
25860	Hickory-Lenoir-Morganton, NC	NC	0.8537	0.8973
26300	Hot Springs, AR	AR	0.9071	0.9354
26420	Houston-Sugar Land-Baytown, TX	TX	0.9946	0.9963
26580	Huntington-Ashland, WV-KY-OH	KY	0.8767	0.9138
26580	Huntington-Ashland, WV-KY-OH	NC	0.8768	0.9139
26580	Huntington-Ashland, WV-KY-OH	OH	0.8757	0.9131
26580	Huntington-Ashland, WV-KY-OH	WV	0.8723	0.9107
26620	Huntsville, AL	AL	0.8646	0.9052
26620	Huntsville, AL	TN	0.8582	0.9006
26820	Idaho Falls, ID	ID	0.9676	0.9777
26900	Indianapolis-Carmel, IN	IN	0.9555	0.9693
26980	Iowa City, IA	IA	0.9422	0.9600
27060	Ithaca, NY	NY	0.9187	0.9436
27140	Jackson, MS	MS	0.8125	0.8675
27180	Jackson, TN	MS	0.8379	0.8859
27620	Jefferson City, MO	MO	0.8605	0.9022
27860	Jonesboro, AR	AR	0.7833	0.8460
27900	Joplin, MO	KS	0.8448	0.8909
27900	Joplin, MO	OK	0.8446	0.8908
28020	Kalamazoo-Portage, MI	MI	0.9979	0.9986
28140	Kansas City, MO-KS	KS	0.9558	0.9695
28140	Kansas City, MO-KS	MO	0.9558	0.9695
28420	Kennewick-Pasco-Richland, WA	ID	0.9659	0.9765
28700	Kingsport-Bristol-Bristol, TN-VA	KY	0.7992	0.8577
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919	0.8523
28940	Knoxville, TN	KY	0.7992	0.8577
28940	Knoxville, TN	TN	0.7919	0.8523
29180	Lafayette, LA	LA	0.8473	0.8927
29404	Lake County-Kenosha County, IL-WI	IL	1.0515	1.0350
29460	Lakeland-Winter Haven, FL	FL	0.8628	0.9039
29540	Lancaster, PA	PA	0.9760	0.9835
29620	Lansing-East Lansing, MI	MI	1.0144	1.0098
29700	Laredo, TX	TX	0.8312	0.8811
29740	Las Cruces, NM	NM	0.9183	0.9433
29820	Las Vegas-Paradise, NV	AZ	1.1811	1.1207
30020	Lawton, OK	OK	0.8306	0.8806
30460	Lexington-Fayette, KY	KY	0.8798	0.9160
30620	Lima, OH	OH	0.9254	0.9483

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
30700	Lincoln, NE	NE	0.9490	0.9648
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8490	0.8940
30980	Longview, TX	TX	0.8593	0.9014
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002	1.1331
31140	Louisville-Jefferson County, KY-IN	KY	0.8848	0.9196
31420	Macon, GA	GA	0.8970	0.9283
31540	Madison, WI	WI	1.1096	1.0738
31900	Mansfield, OH	OH	0.8917	0.9245
32780	Medford, OR	OR	1.0089	1.0061
32820	Memphis, TN-MS-AR	AR	0.8981	0.9290
32820	Memphis, TN-MS-AR	MS	0.8981	0.9290
32820	Memphis, TN-MS-AR	TN	0.8907	0.9238
33124	Miami-Miami Beach-Kendall, FL	FL	1.0222	1.0151
33260	Midland, TX	TX	0.9554	0.9692
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0226	1.0154
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.1027	1.0692
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.1027	1.0692
33540	Missoula, MT	MT	0.8618	0.9032
33660	Mobile, AL	AL	0.7899	0.8509
33700	Modesto, CA	CA	1.2002	1.1331
33740	Monroe, LA	AR	0.8122	0.8672
33740	Monroe, LA	LA	0.8122	0.8672
33780	Monroe, MI	OH	0.9653	0.9761
33860	Montgomery, AL	AL	0.8506	0.8951
34060	Morgantown, WV	WV	0.8266	0.8777
34740	Muskegon-Norton Shores, MI	MI	0.9386	0.9575
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	NC	0.8680	0.9076
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9320	0.9529
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9246	0.9477
35004	Nassau-Suffolk, NY	CT	1.2234	1.1481
35084	Newark-Union, NJ-PA	NJ	1.1099	1.0740
35084	Newark-Union, NJ-PA	NY	1.1332	1.0894
35084	Newark-Union, NJ-PA	PA	1.1296	1.0870
35300	New Haven-Milford, CT	CT	1.1654	1.1105
35380	New Orleans-Metairie-Kenner, LA	LA	0.9005	0.9307
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2817	1.1853
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2619	1.1727
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2884	1.1895
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9265	0.9491
35980	Norwich-New London, CT	RI	1.1412	1.0947
36084	Oakland-Fremont-Hayward, CA	CA	1.5428	1.3457
36140	Ocean City, NJ	DE	1.0903	1.0610

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
36220	Odessa, TX	NM	0.9315	0.9526
36220	Odessa, TX	TX	0.9311	0.9523
36260	Ogden-Clearfield, UT	UT	0.9354	0.9553
36420	Oklahoma City, OK	OK	0.8900	0.9233
36500	Olympia, WA	WA	1.1015	1.0684
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9178	0.9430
37460	Panama City-Lynn Haven-Panama City Beach, FL	AL	0.8002	0.8584
37764	Peabody, MA	NH	1.1021	1.0688
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.8144	0.8688
37900	Peoria, IL	IL	0.9179	0.9430
37964	Philadelphia, PA	NJ	1.1069	1.0720
37964	Philadelphia, PA	PA	1.0663	1.0449
38060	Phoenix-Mesa-Glendale, AZ	AZ	1.0519	1.0353
38220	Pine Bluff, AR	MS	0.8311	0.8810
38300	Pittsburgh, PA	OH	0.8555	0.8986
38300	Pittsburgh, PA	PA	0.8521	0.8962
38300	Pittsburgh, PA	WV	0.8441	0.8904
38340	Pittsfield, MA	NY	1.0158	1.0108
38340	Pittsfield, MA	VT	1.0158	1.0108
38860	Portland-South Portland-Biddeford, ME	ME	0.9509	0.9661
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1221	1.0821
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1212	1.0815
38940	Port St. Lucie, FL	FL	1.0283	1.0193
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1246	1.0837
39340	Provo-Orem, UT	UT	0.9272	0.9496
39580	Raleigh-Cary, NC	NC	0.9713	0.9803
39740	Reading, PA	PA	0.8856	0.9202
39820	Redding, CA	CA	1.3277	1.2142
39900	Reno-Sparks, NV	NV	1.0439	1.0299
40060	Richmond, VA	VA	0.9536	0.9680
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1429	1.0958
40220	Roanoke, VA	VA	0.8864	0.9207
40220	Roanoke, VA	WV	0.8820	0.9176
40380	Rochester, NY	NY	0.8708	0.9096
40420	Rockford, IL	IL	0.9874	0.9914
40484	Rockingham County-Strafford County, NH	ME	1.0218	1.0149
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3217	1.2105
40980	Saginaw-Saginaw Township North, MI	MI	0.9102	0.9376
41100	St. George, UT	UT	0.9311	0.9523
41180	St. Louis, MO-IL	IL	0.8955	0.9272
41180	St. Louis, MO-IL	MO	0.8955	0.9272

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
41620	Salt Lake City, UT	UT	0.9362	0.9559
41700	San Antonio-New Braunfels, TX	TX	0.9071	0.9354
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5855	1.3711
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002	1.1331
42100	Santa Cruz-Watsonville, CA	CA	1.6059	1.3832
42140	Santa Fe, NM	NM	1.0400	1.0272
42220	Santa Rosa-Petaluma, CA	CA	1.5173	1.3304
42340	Savannah, GA	GA	0.8858	0.9203
42340	Savannah, GA	SC	0.8858	0.9203
42644	Seattle-Bellevue-Everett, WA	WA	1.1272	1.0855
43300	Sherman-Denison, TX	OK	0.8445	0.8907
43340	Shreveport-Bossier City, LA	LA	0.8651	0.9055
43580	Sioux City, IA-NE-SD	NE	0.8968	0.9281
43620	Sioux Falls, SD	SD	0.9388	0.9577
43780	South Bend-Mishawaka, IN-MI	IN	0.9488	0.9646
43900	Spartanburg, SC	SC	0.8970	0.9283
44060	Spokane, WA	ID	1.0384	1.0261
44100	Springfield, IL	IL	0.8948	0.9267
44140	Springfield, MA	NH	1.0258	1.0176
44180	Springfield, MO	AR	0.8413	0.8884
44180	Springfield, MO	MO	0.8413	0.8884
44940	Sumter, SC	SC	0.8438	0.8902
45060	Syracuse, NY	NY	0.9710	0.9800
45220	Tallahassee, FL	GA	0.8795	0.9158
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9094	0.9370
45460	Terre Haute, IN	IN	0.8757	0.9131
45780	Toledo, OH	OH	0.9246	0.9477
45820	Topeka, KS	KS	0.8948	0.9267
46140	Tulsa, OK	OK	0.8798	0.9160
46220	Tuscaloosa, AL	AL	0.8015	0.8594
46220	Tuscaloosa, AL	MS	0.8022	0.8599
46340	Tyler, TX	TX	0.8259	0.8772
46540	Utica-Rome, NY	NY	0.8737	0.9117
46660	Valdosta, GA	GA	0.7840	0.8465
46700	Vallejo-Fairfield, CA	CA	1.4010	1.2597
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8954	0.9271
47580	Warner Robins, GA	GA	0.8470	0.8925
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0559	1.0380
48140	Wausau, WI	WI	0.9113	0.9384
48620	Wichita, KS	KS	0.8756	0.9130
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0690	1.0468

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
48900	Wilmington, NC	SC	0.9265	0.9491
49180	Winston-Salem, NC	NC	0.8974	0.9285
49180	Winston-Salem, NC	VA	0.8973	0.9285
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8555	0.8986
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8521	0.8962

TABLE 4D-1.—PROPOSED RURAL FLOOR BUDGET NEUTRALITY FACTORS FOR ACUTE CARE HOSPITALS—FY 2011

[The rural floor budget neutrality adjustment factor is a 100 percent State-level factor.]

State	Proposed Rural Floor Budget Neutrality Adjustment Factor
Alabama	0.99910
Alaska	0.94328
Arizona	1.00000
Arkansas	1.00000
California	0.97557
Colorado	0.98680
Connecticut	0.99483
Delaware	1.00000
Washington, D.C.	1.00000
Florida	0.99847
Georgia	1.00000
Hawaii	1.00000
Idaho	1.00000
Illinois	1.00000
Indiana	1.00000
Iowa	0.99954
Kansas	1.00000
Kentucky	0.99973
Louisiana	1.00000
Maine	1.00000
Maryland*	1.00000
Massachusetts	1.00000
Michigan	1.00000
Minnesota	1.00000
Mississippi	1.00000
Missouri	1.00000
Montana	0.99988
Nebraska	1.00000
Nevada	1.00000
New Hampshire	1.00000
New Jersey **	0.97946
New Mexico	1.00000
New York	1.00000
North Carolina	0.99989
North Dakota	1.00000
Ohio	0.99864
Oklahoma	0.99975

State	Proposed Rural Floor Budget Neutrality Adjustment Factor
Oregon	0.99974
Pennsylvania	0.99681
Puerto Rico	1.00000
Rhode Island	1.00000
South Carolina	1.00000
South Dakota	1.00000
Tennessee	0.99171
Texas	0.99956
Utah	1.00000
Vermont	1.00000
Virginia	0.99977
Washington	0.99891
West Virginia	0.99479
Wisconsin	1.00000
Wyoming	1.00000

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS ratesetting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see TABLE 4B).

TABLE 4D-2.--URBAN AREAS WITH ACUTE CARE HOSPITALS RECEIVING THE PROPOSED STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX--FY 2011

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State*	Proposed Rural or Imputed Floor Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1069
11260	Anchorage, AK	AK	1.1919
12100	Atlantic City-Hammonton, NJ	NJ	1.1069
12540	Bakersfield-Delano, CA	CA	1.2002
15804	Camden, NJ	NJ	1.1069
16940	Cheyenne, WY	WY	0.9392
17020	Chico, CA	CA	1.2002
17300	Clarksville, TN-KY	KY	0.7992
17300	Clarksville, TN-KY	TN	0.7919
17420	Cleveland, TN	TN	0.7919
17820	Colorado Springs, CO	CO	0.9581
19060	Cumberland, MD-WV	MD	0.9305
19500	Decatur, IL	IL	0.8380
20100	Dover, DE	DE	1.0090
20764	Edison-New Brunswick, NJ	NJ	1.1069
20940	El Centro, CA	CA	1.2002
21500	Erie, PA	PA	0.8521
21780	Evansville, IN-KY	IN	0.8399
21820	Fairbanks, AK	AK	1.1919
22020	Fargo, ND-MN	MN	0.9146
22140	Farmington, NM	NM	0.9030
22660	Fort Collins-Loveland, CO	CO	0.9581
22900	Fort Smith, AR-OK	OK	0.8052
23420	Fresno, CA	CA	1.2002
23460	Gadsden, AL	AL	0.7448
24220	Grand Forks, ND-MN	MN	0.9146
24500	Great Falls, MT	MT	0.8439
24540	Greeley, CO	CO	0.9581
25260	Hanford-Corcoran, CA	CA	1.2002
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251
27340	Jacksonville, NC	NC	0.8476
27740	Johnson City, TN	TN	0.7919

CBSA Code	Urban Area	State*	Proposed Rural or Imputed Floor Wage Index
27780	Johnstown, PA	PA	0.8521
28420	Kennewick-Pasco-Richland, WA	WA	1.0107
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8060
28940	Knoxville, TN	TN	0.7919
30140	Lebanon, PA	PA	0.8521
30300	Lewiston, ID-WA	WA	1.0107
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002
31460	Madera-Chowchilla, CA	CA	1.2002
31700	Manchester-Nashua, NH	NH	1.0054
31740	Manhattan, KS	KS	0.8027
32780	Medford, OR	OR	1.0089
32900	Merced, CA	CA	1.2002
33700	Modesto, CA	CA	1.2002
34100	Morristown, TN	TN	0.7919
34580	Mount Vernon-Anacortes, WA	WA	1.0107
34620	Muncie, IN	IN	0.8399
36140	Ocean City, NJ	NJ	1.1069
37380	Palm Coast, FL	FL	0.8458
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8458
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8555
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7536
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8458
39380	Pueblo, CO	CO	0.9581
40140	Riverside-San Bernardino-Ontario, CA	CA	1.2002
41540	Salisbury, MD	MD	0.9305
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.2002
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.2002
42540	Scranton--Wilkes-Barre, PA	PA	0.8521
44600	Steubenville-Weirton, OH-WV	OH	0.8555
44600	Steubenville-Weirton, OH-WV	WV	0.7536
44940	Sumter, SC	SC	0.8438
45500	Texarkana, TX-Texarkana, AR	TX	0.8018
45940	Trenton-Ewing, NJ	NJ	1.1069
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1069
47300	Visalia-Porterville, CA	CA	1.2002
47940	Waterloo-Cedar Falls, IA	IA	0.8533
48300	Wenatchee-East Wenatchee, WA	WA	1.0107
48540	Wheeling, WV-OH	OH	0.8555
48540	Wheeling, WV-OH	WV	0.7536
48700	Williamsport, PA	PA	0.8521
48864	Wilmington, DE-MD-NJ	NJ	1.1069
49420	Yakima, WA	WA	1.0107
49700	Yuba City, CA	CA	1.2002

TABLE 4E.—URBAN CBSAs AND CONSTITUENT COUNTIES FOR ACUTE CARE HOSPITALS—FY 2011

CBSA Code	Urban Area (Constituent Counties)
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR
10420	Akron, OH Portage County, OH Summit County, OH
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA
11020	Altoona, PA Blair County, PA
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX
11180	Ames, IA Story County, IA
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK
11300	Anderson, IN Madison County, IN
11340	Anderson, SC Anderson County, SC
11460	Ann Arbor, MI Washtenaw County, MI
11500	Anniston-Oxford, AL Calhoun County, AL
11540	Appleton, WI Calumet County, WI Outagamie County, WI
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA

CBSA Code	Urban Area (Constituent Counties)
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ Hammonton County, NJ
12220	Auburn-Opelika, AL Lee County, AL
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX
12540	Bakersfield-Delano, CA Kern County, CA
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
12620	Bangor, ME Penobscot County, ME
12700	Barnstable Town, MA Barnstable County, MA
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA
12980	Battle Creek, MI Calhoun County, MI
13020	Bay City, MI Bay County, MI
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX
13380	Bellingham, WA Whatcom County, WA
13460	Bend, OR Deschutes County, OR

CBSA Code	Urban Area (Constituent Counties)
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD
13740	Billings, MT Carbon County, MT Yellowstone County, MT
13780	Binghamton, NY Broome County, NY Tioga County, NY
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL
13900	Bismarck, ND Burleigh County, ND Morton County, ND
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN
14060	Bloomington-Normal, IL McLean County, IL
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA
14500	Boulder, CO Boulder County, CO

CBSA Code	Urban Area (Constituent Counties)
14540	Bowling Green, KY Edmonson County, KY Warren County, KY
14740	Bremerton-Silverdale, WA Kitsap County, WA
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT
15180	Brownsville-Harlingen, TX Cameron County, TX
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY
15500	Burlington, NC Alamance County, NC
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH
15980	Cape Coral-Fort Myers, FL Lee County, FL
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO
16180	Carson City, NV Carson City, NV
16220	Casper, WY Natrona County, WY

CBSA Code	Urban Area (Constituent Counties)
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC Summerville County, SC
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN
16940	Cheyenne, WY Laramie County, WY

CBSA Code	Urban Area (Constituent Counties)
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL
17020	Chico, CA Butte County, CA
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN
17420	Cleveland, TN Bradley County, TN Polk County, TN
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH
17660	Coeur d'Alene, ID Kootenai County, ID

CBSA Code	Urban Area (Constituent Counties)
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX
17820	Colorado Springs, CO El Paso County, CO Teller County, CO
17860	Columbia, MO Boone County, MO Howard County, MO
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA
18020	Columbus, IN Bartholomew County, IN
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
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX
18700	Corvallis, OR Benton County, OR
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL

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

CBSA Code	Urban Area (Constituent Counties)
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL
20100	Dover, DE Kent County, DE
20220	Dubuque, IA Dubuque County, IA
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI

CBSA Code	Urban Area (Constituent Counties)
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ New Brunswick County, NJ Ocean County, NJ Somerset County, NJ
20940	El Centro, CA Imperial County, CA
21060	Elizabethtown, KY Hardin County, KY Larue County, KY
21140	Elkhart-Goshen, IN Elkhart County, IN
21300	Elmira, NY Chemung County, NY
21340	El Paso, TX El Paso County, TX
21500	Erie, PA Erie County, PA
21660	Eugene-Springfield, OR Lane County, OR
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY
21820	Fairbanks, AK Fairbanks North Star Borough, AK
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR
22020	Fargo, ND-MN Clay County, MN Cass County, ND
22140	Farmington, NM San Juan County, NM
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC

CBSA Code	Urban Area (Constituent Counties)
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO
22380	Flagstaff, AZ Coconino County, AZ
22420	Flint, MI Genesee County, MI
22500	Florence, SC Darlington County, SC Florence County, SC
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL
22540	Fond du Lac, WI Fond du Lac County, WI
22660	Fort Collins-Loveland, CO Larimer County, CO
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX
23420	Fresno, CA Fresno County, CA
23460	Gadsden, AL Etowah County, AL
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL

CBSA Code	Urban Area (Constituent Counties)
23580	Gainesville, GA Hall County, GA
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN
24020	Glens Falls, NY Warren County, NY Washington County, NY
24140	Goldsboro, NC Wayne County, NC
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND
24300	Grand Junction, CO Mesa County, CO
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI
24500	Great Falls, MT Cascade County, MT
24540	Greeley, CO Weld County, CO
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC
24780	Greenville, NC Greene County, NC Pitt County, NC
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC

CBSA Code	Urban Area (Constituent Counties)
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV
25260	Hanford-Corcoran, CA Kings County, CA
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA
26100	Holland-Grand Haven, MI Ottawa County, MI
26180	Honolulu, HI Honolulu County, HI
26300	Hot Springs, AR Garland County, AR

CBSA Code	Urban Area (Constituent Counties)
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA
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
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV
26620	Huntsville, AL Limestone County, AL Madison County, AL
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID
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
26980	Iowa City, IA Johnson County, IA Washington County, IA
27060	Ithaca, NY Tompkins County, NY
27100	Jackson, MI Jackson County, MI

CBSA Code	Urban Area (Constituent Counties)
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS
27180	Jackson, TN Chester County, TN Madison County, TN
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL
27340	Jacksonville, NC Onslow County, NC
27500	Janesville, WI Rock County, WI
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN
27780	Johnstown, PA Cambria County, PA
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR
27900	Joplin, MO Jasper County, MO Newton County, MO
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI
28100	Kankakee-Bradley, IL Kankakee County, IL

CBSA Code	Urban Area (Constituent Counties)
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
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA
28740	Kingston, NY Ulster County, NY
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN
29020	Kokomo, IN Howard County, IN Tipton County, IN
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI

CBSA Code	Urban Area (Constituent Counties)
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ
29460	Lakeland-Winter Haven, FL Polk County, FL Winter Haven County, FL
29540	Lancaster, PA Lancaster County, PA
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI
29700	Laredo, TX Webb County, TX
29740	Las Cruces, NM Dona Ana County, NM
29820	Las Vegas-Paradise, NV Clark County, NV
29940	Lawrence, KS Douglas County, KS
30020	Lawton, OK Comanche County, OK
30140	Lebanon, PA Lebanon County, PA
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA
30340	Lewiston-Auburn, ME Androscoggin County, ME
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY
30620	Lima, OH Allen County, OH
30700	Lincoln, NE Lancaster County, NE Seward County, NE
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR
30860	Logan, UT-ID Franklin County, ID Cache County, UT
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX
31020	Longview, WA Cowlitz County, WA
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA
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

CBSA Code	Urban Area (Constituent Counties)
31180	Lubbock, TX Crosby County, TX Lubbock County, TX
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA
31460	Madera-Chowchilla, CA Madera County, CA
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI
31700	Manchester-Nashua, NH Hillsborough County, NH
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN
31900	Mansfield, OH Richland County, OH
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX
32780	Medford, OR Jackson County, OR

CBSA Code	Urban Area (Constituent Counties)
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
32900	Merced, CA Merced County, CA
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL
33140	Michigan City-La Porte, IN LaPorte County, IN
33260	Midland, TX Midland County, TX
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI
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
33540	Missoula, MT Missoula County, MT
33660	Mobile, AL Mobile County, AL
33700	Modesto, CA Stanislaus County, CA

CBSA Code	Urban Area (Constituent Counties)
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA
33780	Monroe, MI Monroe County, MI
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL
34060	Morgantown, WV Monongalia County, WV Preston County, WV
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN
34580	Mount Vernon-Anacortes, WA Skagit County, WA
34620	Muncie, IN Delaware County, IN
34740	Muskegon-Norton Shores, MI Muskegon County, MI
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC
34900	Napa, CA Napa County, CA
34940	Naples-Marco Island, FL Collier County, FL
34980	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

CBSA Code	Urban Area (Constituent Counties)
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA
35300	New Haven-Milford, CT New Haven County, CT
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
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
35660	Niles-Benton Harbor, MI Berrien County, MI
35840	North Port-Bradenton-Sarasota, FL Manatee County, FL Sarasota County, FL
35980	Norwich-New London, CT New London County, CT
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA
36100	Ocala, FL Marion County, FL

CBSA Code	Urban Area (Constituent Counties)
36140	Ocean City, NJ Cape May County, NJ
36220	Odessa, TX Ector County, TX
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT
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
36500	Olympia, WA Thurston County, WA
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL
36780	Oshkosh-Neenah, WI Winnebago County, WI
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL
37380	Palm Coast, FL Flager County, FL

CBSA Code	Urban Area (Constituent Counties)
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV
37700	Pascagoula, MS George County, MS Jackson County, MS
37764	Peabody, MA Essex County, MA
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA
38340	Pittsfield, MA Berkshire County, MA

CBSA Code	Urban Area (Constituent Counties)
38540	Pocatello, ID Bannock County, ID Power County, ID
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY
39140	Prescott, AZ Yavapai County, AZ
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI
39340	Provo-Orem, UT Juab County, UT Utah County, UT
39380	Pueblo, CO Pueblo County, CO
39460	Punta Gorda, FL Charlotte County, FL
39540	Racine, WI Racine County, WI

CBSA Code	Urban Area (Constituent Counties)
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC
39660	Rapid City, SD Meade County, SD Pennington County, SD
39740	Reading, PA Berks County, PA
39820	Redding, CA Shasta County, CA
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA

CBSA Code	Urban Area (Constituent Counties)
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY
40420	Rockford, IL Boone County, IL Winnebago County, IL
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC
40660	Rome, GA Floyd County, GA
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI
41060	St. Cloud, MN Benton County, MN Stearns County, MN
41100	St. George, UT Washington County, UT

CBSA Code	Urban Area (Constituent Counties)
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO
41420	Salem, OR Marion County, OR Polk County, OR
41500	Salinas, CA Monterey County, CA
41540	Salisbury, MD Somerset County, MD Wicomico County, MD
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT
41660	San Angelo, TX Irion County, TX Tom Green County, TX

CBSA Code	Urban Area (Constituent Counties)
41700	San Antonio-New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA
41780	Sandusky, OH Erie County, OH
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA
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
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA

CBSA Code	Urban Area (Constituent Counties)
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA
42140	Santa Fe, NM Santa Fe County, NM
42220	Santa Rosa-Petaluma, CA Sonoma County, CA
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA
42680	Sebastian-Vero Beach, FL Indian River County, FL
43100	Sheboygan, WI Sheboygan County, WI
43300	Sherman-Denison, TX Grayson County, TX
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI

CBSA Code	Urban Area (Constituent Counties)
43900	Spartanburg, SC Spartanburg County, SC
44060	Spokane, WA Spokane County, WA
44100	Springfield, IL Menard County, IL Sangamon County, IL
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO
44220	Springfield, OH Clark County, OH
44300	State College, PA Centre County, PA
44600	Steubenville-Weirton, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV
44700	Stockton, CA San Joaquin County, CA
44940	Sumter, SC Sumter County, SC
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY
45104	Tacoma, WA Pierce County, WA
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL

CBSA Code	Urban Area (Constituent Counties)
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS
45940	Trenton-Ewing, NJ Mercer County, NJ
46060	Tucson, AZ Pima County, AZ
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL
46340	Tyler, TX Smith County, TX

CBSA Code	Urban Area (Constituent Counties)
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA
46700	Vallejo-Fairfield, CA Solano County, CA
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA
47300	Visalia-Porterville, CA Tulare County, CA
47380	Waco, TX McLennan County, TX
47580	Warner Robins, GA Houston County, GA

CBSA Code	Urban Area (Constituent Counties)
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI
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
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA
48140	Wausau, WI Marathon County, WI
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV

CBSA Code	Urban Area (Constituent Counties)
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX
48700	Williamsport, PA Lycoming County, PA
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC
49340	Worcester, MA Worcester County, MA
49420	Yakima, WA Yakima County, WA
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR
49620	York-Hanover, PA York County, PA
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA

CBSA Code	Urban Area (Constituent Counties)
49700	Yuba City, CA Sutter County, CA Yuba County, CA
49740	Yuma, AZ Yuma County, AZ

TABLE 4F.—PROPOSED PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS BY CBSA--FY 2011

(Note: The rural floor budget neutrality adjustment is not applicable to the Puerto Rico specific wage index.)

CBSA Code	Area	Proposed Wage Index	Proposed GAF	Wage Index – Reclassified Hospitals	GAF – Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.8107	0.8661	------	------
21940	Fajardo, PR	0.9207	0.9450	------	------
25020	Guayama, PR	0.8570	0.8997	------	------
32420	Mayagüez, PR	0.8593	0.9014	------	------
38660	Ponce, PR	1.0201	1.0137	------	------
41900	San Germán-Cabo Rojo, PR	1.0812	1.0549	------	------
41980	San Juan-Caguas-Guaynabo, PR	1.0224	1.0153	------	------
49500	Yauco, PR	0.8385	0.8864	------	------

TABLE 4J.—PROPOSED OUT-MIGRATION ADJUSTMENT FOR ACUTE CARE HOSPITALS--FY 2011

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attn: Wage Index Adjustment Waivers, Division of Acute Care, Room C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010010		0.0296	MARSHALL	01470
010012		0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010021		0.0123	DALE	01220
010022	*	0.1128	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0062	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0113	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046	*	0.0113	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0062	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0097	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
010065	*	0.0245	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0309	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150		0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019		0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
050002	*	0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050042	*	0.0162	TEHAMA	05620
050043	*	0.0010	ALAMEDA	05000
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075	*	0.0010	ALAMEDA	05000
050084	*	0.0132	SAN JOAQUIN	05490
050090	*	0.0058	SONOMA	05590
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050133		0.0178	YUBA	05680

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
050136	*	0.0058	SONOMA	05590
050150	*	0.0342	NEVADA	05390
050167		0.0132	SAN JOAQUIN	05490
050174	*	0.0058	SONOMA	05590
050195	*	0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211	*	0.0010	ALAMEDA	05000
050264	*	0.0010	ALAMEDA	05000
050283	*	0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050305	*	0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320	*	0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050366	*	0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050444		0.0233	MERCED	05340
050488	*	0.0010	ALAMEDA	05000
050512	*	0.0010	ALAMEDA	05000
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050547	*	0.0058	SONOMA	05590
050667	*	0.0180	NAPA	05380
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050748	*	0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060027	*	0.0069	BOULDER	06060
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060121	*	0.0042	WELD	06610
070003	*	0.0020	WINDHAM	07070
070004	*	0.0135	LITCHFIELD	07020
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070011	*	0.0135	LITCHFIELD	07020
070015	*	0.0135	LITCHFIELD	07020
070018	*	0.0045	FAIRFIELD	07000

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
070020		0.0101	MIDDLESEX	07030
070021	*	0.0020	WINDHAM	07070
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0097	WALTON	10650
100118	*	0.0177	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0151	OKEECHOBEE	10460
100290	*	0.0452	SUMTER	10590
100292	*	0.0097	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190	*	0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
140110	*	0.0315	LA SALLE	14580
140116	*	0.0041	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176	*	0.0041	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0402	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049		0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066		0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088		0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184		0.0047	CALDWELL	19100
190190	*	0.0047	CALDWELL	19100
190191		0.0187	ST. LANDRY	19480
190246		0.0047	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0331	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0254	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
220001	*	0.0064	WORCESTER	22170
220002	*	0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011	*	0.0271	MIDDLESEX	22090
220019	*	0.0064	WORCESTER	22170
220025	*	0.0064	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049	*	0.0271	MIDDLESEX	22090
220058	*	0.0064	WORCESTER	22170
220062	*	0.0064	WORCESTER	22170
220063	*	0.0271	MIDDLESEX	22090
220070	*	0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082	*	0.0271	MIDDLESEX	22090
220084	*	0.0271	MIDDLESEX	22090
220090	*	0.0064	WORCESTER	22170
220095	*	0.0064	WORCESTER	22170
220098	*	0.0271	MIDDLESEX	22090
220101	*	0.0271	MIDDLESEX	22090
220105	*	0.0271	MIDDLESEX	22090
220163	*	0.0064	WORCESTER	22170
220171	*	0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220175	*	0.0271	MIDDLESEX	22090
220176	*	0.0064	WORCESTER	22170

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
230002	*	0.0043	WAYNE	23810
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0021	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0025	OAKLAND	23620
230165	*	0.0043	WAYNE	23810
230174	*	0.0220	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230227	*	0.0021	MACOMB	23490
230244	*	0.0043	WAYNE	23810

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
230297	*	0.0043	WAYNE	23810
230301	*	0.0025	OAKLAND	23620
230302	*	0.0025	OAKLAND	23620
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064		0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
260059		0.0077	LACLEDE	26520
260064		0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0087	ST. FRANCOIS	26930
280077	*	0.0080	DODGE	28260
290002	*	0.0277	LYON	29090
300011	*	0.0238	HILLSBOROUGH	30050
300012	*	0.0238	HILLSBOROUGH	30050
300017	*	0.0396	ROCKINGHAM	30070
300020	*	0.0238	HILLSBOROUGH	30050
300023	*	0.0396	ROCKINGHAM	30070
300029	*	0.0396	ROCKINGHAM	30070
300034	*	0.0238	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310015	*	0.0254	MORRIS	31300
310017	*	0.0254	MORRIS	31300
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
310050	*	0.0254	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310119	*	0.0268	ESSEX	31200
320003	*	0.0490	SAN MIGUEL	32230
320011		0.0344	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
320088		0.0024	DONA ANA	32060
330004		0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103		0.0131	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0034	STEUBEN	33690
330151		0.0034	STEUBEN	33690
330167	*	0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0034	STEUBEN	33690

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037	*	0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085	*	0.0250	DAVIDSON	34280
340096	*	0.0250	DAVIDSON	34280
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0319	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0075	HURON	36400
360070		0.0038	STARK	36770
360071		0.0035	VAN WERT	36820
360084		0.0038	STARK	36770
360086	*	0.0186	CLARK	36110
360096		0.0071	COLUMBIANA	36140
360107		0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
360131		0.0038	STARK	36770
360151		0.0038	STARK	36770
360156		0.0119	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360245	*	0.0133	ASHTABULA	36030
360355		0.0186	CLARK	36110
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149		0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044		0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096		0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
390146		0.0022	WARREN	39740
390150		0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0215	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0147	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
420005		0.0012	DILLON	42160
420007	*	0.0027	SPARTANBURG	42410
420019		0.0158	CHESTER	42110
420020	*	0.0024	GEORGETOWN	42210
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0176	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0008	MARLBORO	42340
420055		0.0029	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420083	*	0.0027	SPARTANBURG	42410
420098		0.0024	GEORGETOWN	42210
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008		0.0449	HENDERSON	44380
440016		0.0144	CARROLL	44080
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060		0.0338	GIBSON	44260
440063		0.0033	WASHINGTON	44890

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440105		0.0033	WASHINGTON	44890
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148		0.0296	DE KALB	44200
440174	*	0.0312	HAYWOOD	44370
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0230	BRADLEY	44050
450032	*	0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144	*	0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370	*	0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450395		0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450497		0.0375	MONTAGUE	45800

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
450539		0.0067	HALE	45582
450547	*	0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565	*	0.0470	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450597		0.0003	DE WITT	45420
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813		0.0126	ANDERSON	45000
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0383	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0383	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1088	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0187	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500024		0.0065	THURSTON	50330
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
500139		0.0065	THURSTON	50330
500143		0.0065	THURSTON	50330
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0193	SAUK	52550
520096	*	0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
520160		0.0027	OUTAGAMIE	52430
520198		0.0022	WINNEBAGO	52690

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.1241	31.7	41.8
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.5332	17.7	22.8
003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.0135	30.0	36.6
004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.1832	22.2	27.1
005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2640	15.0	20.0
006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8067	8.3	9.2
007	No	No	PRE	SURG	LUNG TRANSPLANT	9.3918	15.6	18.7
008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9951	10.2	11.8
010	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.7220	8.6	9.7
011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7558	12.3	15.6
012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.1179	8.5	10.1
013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9480	5.7	6.7
014	No	No	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.3961	20.7	27.7
015	No	No	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT	5.8721	16.7	19.2
020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2168	14.0	17.2
021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2673	12.2	13.9
022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.1377	6.6	8.4
023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	5.0829	8.3	11.8
024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.4948	5.7	8.1
025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.7528	8.8	11.5
026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9804	5.8	7.3
027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1382	3.0	3.9
028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.3583	10.1	13.1
029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.8798	4.7	6.6
030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6452	2.5	3.3
031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1020	8.5	12.2
032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9339	3.7	5.4
033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3695	2.1	2.7
034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5290	4.7	7.0
035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.1572	2.2	3.2
036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.6539	1.3	1.5
037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1652	5.8	8.4
038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5610	2.4	3.5
039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0278	1.4	1.7
040	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9264	9.0	12.2
041	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1447	5.0	6.7
042	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6950	2.3	3.2
052	No	No	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.5964	4.5	6.6

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
053	No	No	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8417	2.9	3.6
054	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.4801	4.6	6.3
055	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0651	3.5	4.6
056	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6720	5.5	7.2
057	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9316	3.7	4.9
058	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5781	5.5	7.3
059	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	0.9818	4.1	4.9
060	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7525	3.2	3.8
061	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.9397	6.4	8.4
062	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9450	4.8	5.6
063	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5296	3.4	3.9
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8601	5.1	6.9
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1637	4.0	4.8
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8174	2.7	3.3
067	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4176	4.2	5.5
068	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8746	2.7	3.3
069	No	No	01	MED	TRANSIENT ISCHEMIA	0.7292	2.3	2.8
070	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.8345	5.6	7.4
071	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1008	4.1	5.1
072	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7468	2.5	3.1
073	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2959	4.2	5.6
074	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8592	3.2	4.1
075	No	No	01	MED	VIRAL MENINGITIS W CC/MCC	1.6538	5.5	7.0
076	No	No	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.9054	3.3	3.9
077	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.7332	5.1	6.4
078	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	1.0145	3.5	4.4
079	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7500	2.6	3.1
080	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1831	3.6	4.9
081	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7350	2.7	3.4
082	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0028	3.5	6.1
083	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3194	3.4	4.7
084	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8899	2.2	2.8
085	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1345	5.2	7.2
086	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.1979	3.7	4.6
087	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7872	2.3	2.9
088	No	No	01	MED	CONCUSSION W MCC	1.5102	4.2	5.5
089	No	No	01	MED	CONCUSSION W CC	0.9644	2.9	3.7
090	No	No	01	MED	CONCUSSION W/O CC/MCC	0.6943	1.9	2.3
091	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6299	4.4	6.2
092	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9372	3.3	4.2
093	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.6800	2.3	2.9
094	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6910	8.9	11.8
095	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3934	6.6	8.4
096	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	1.9171	4.6	5.7

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097	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.2271	9.0	11.6
098	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.9053	6.4	7.9
099	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2170	4.1	5.2
100	Yes	No	01	MED	SEIZURES W MCC	1.5091	4.5	6.0
101	Yes	No	01	MED	SEIZURES W/O MCC	0.7588	2.8	3.4
102	No	No	01	MED	HEADACHES W MCC	0.9997	3.1	4.3
103	No	No	01	MED	HEADACHES W/O MCC	0.6691	2.4	3.0
113	No	No	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.8278	3.9	5.6
114	No	No	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.9224	2.0	2.6
115	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.2130	3.4	4.6
116	No	No	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.2920	3.0	4.5
117	No	No	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.7393	1.6	2.0
121	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9040	4.1	5.1
122	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6451	3.3	4.0
123	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7135	2.2	2.7
124	No	No	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1861	3.8	5.3
125	No	No	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6819	2.6	3.4
129	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.2555	3.7	5.2
130	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2316	2.3	2.9
131	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.0829	4.1	5.6
132	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.2451	2.1	2.7
133	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.6960	3.6	5.4
134	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8518	1.7	2.1
135	No	No	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.9029	4.3	6.3
136	No	No	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	0.9772	1.7	2.2
137	No	No	03	SURG	MOUTH PROCEDURES W CC/MCC	1.2952	3.6	5.0
138	No	No	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7822	1.9	2.5
139	No	No	03	SURG	SALIVARY GLAND PROCEDURES	0.8827	1.4	1.8
146	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.1722	6.5	9.0
147	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2284	4.1	5.7
148	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8118	2.4	3.3
149	No	No	03	MED	DYSEQUILIBRIUM	0.6363	2.2	2.6
150	No	No	03	MED	EPISTAXIS W MCC	1.2811	3.7	5.0
151	No	No	03	MED	EPISTAXIS W/O MCC	0.6366	2.3	2.9
152	No	No	03	MED	OTITIS MEDIA & URI W MCC	0.9623	3.3	4.3
153	No	No	03	MED	OTITIS MEDIA & URI W/O MCC	0.6256	2.5	3.1
154	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.3957	4.3	5.8
155	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.9032	3.3	4.2
156	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6184	2.4	2.9
157	No	No	03	MED	DENTAL & ORAL DISEASES W MCC	1.5699	4.8	6.7
158	No	No	03	MED	DENTAL & ORAL DISEASES W CC	0.8951	3.3	4.3
159	No	No	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5858	2.1	2.7
163	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.0701	11.5	14.0
164	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6177	6.2	7.4
165	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7756	3.7	4.4
166	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7415	9.5	12.0
167	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0537	5.8	7.4
168	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3012	3.3	4.3
175	Yes	No	04	MED	PULMONARY EMBOLISM W MCC	1.6088	5.7	6.8
176	Yes	No	04	MED	PULMONARY EMBOLISM W/O MCC	1.0666	4.2	4.9

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177	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0651	6.8	8.6
178	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4859	5.6	6.8
179	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9836	4.1	5.0
180	No	No	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7310	5.7	7.5
181	No	No	04	MED	RESPIRATORY NEOPLASMS W CC	1.2155	4.2	5.4
182	No	No	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8086	2.8	3.7
183	No	No	04	MED	MAJOR CHEST TRAUMA W MCC	1.4874	5.2	6.5
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9670	3.6	4.3
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6761	2.6	3.0
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5600	5.3	6.7
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.0991	3.9	4.9
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7628	2.8	3.5
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2776	4.3	5.5
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1894	4.5	5.5
191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9712	3.8	4.6
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7200	3.1	3.7
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4753	5.3	6.5
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	1.0124	4.2	5.0
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7073	3.1	3.7
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6053	5.6	7.0
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1149	4.2	5.1
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8149	3.1	3.8
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.7760	6.2	8.0
200	No	No	04	MED	PNEUMOTHORAX W CC	1.0198	3.7	4.8
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7167	2.8	3.5
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8395	3.4	4.1
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6051	2.6	3.2
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6705	2.1	2.7
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.3018	4.0	5.3
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7546	2.6	3.3
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.1936	12.6	14.8
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2522	5.1	7.0
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.7451	7.0	12.6
216	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	10.0309	14.7	17.1
217	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.8081	9.8	11.0
218	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.3407	7.2	8.0
219	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	8.0975	10.8	13.1
220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.3923	7.2	8.0
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.4941	5.6	6.0
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.5634	9.4	11.9
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.4649	4.5	6.2
224	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.6030	7.7	9.7
225	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	6.0613	4.2	5.3
226	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.4967	5.0	7.8
227	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.2285	2.0	3.1

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					W/O MCC			
228	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.6151	11.8	14.2
229	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.7934	7.3	8.3
230	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.5608	4.6	5.5
231	No	No	05	SURG	CORONARY BYPASS W PTCA W MCC	7.8893	10.9	12.9
232	No	No	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.8492	8.5	9.4
233	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.2273	12.1	13.7
234	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.8441	8.2	8.9
235	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8556	9.3	10.8
236	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.7839	6.0	6.5
237	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.1927	7.1	10.2
238	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	3.1008	2.9	4.2
239	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.5646	11.3	14.3
240	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6639	7.8	9.6
241	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4626	5.0	6.0
242	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7327	6.3	8.1
243	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6570	3.8	4.9
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.0486	2.2	2.8
245	No	No	05	SURG	AICD GENERATOR PROCEDURES	4.2684	2.5	3.8
246	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.1923	3.5	5.0
247	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9812	1.8	2.3
248	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	2.9295	4.4	6.0
249	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.7814	2.2	2.8
250	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.8844	5.0	7.0
251	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.8040	2.1	2.9
252	No	No	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9853	5.2	7.9
253	No	No	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4104	4.4	6.0
254	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.6244	2.0	2.7
255	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.4930	7.0	9.2
256	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.5992	5.6	7.0
257	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9629	3.4	4.3
258	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.8707	5.2	7.0
259	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.8381	2.4	3.2
260	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.5636	7.7	10.8
261	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.6515	3.2	4.5
262	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.1284	2.0	2.6
263	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.7560	3.5	5.6
264	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.5446	5.5	8.3
265	No	No	05	SURG	AICD LEAD PROCEDURES	2.3205	2.2	3.3
280	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.8435	5.2	6.6
281	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1852	3.6	4.4

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
282	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.8042	2.2	2.8
283	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7107	3.2	5.1
284	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.8884	2.1	3.0
285	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5717	1.4	1.8
286	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	1.9978	4.8	6.5
287	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0876	2.5	3.2
288	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.9607	8.6	10.9
289	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8355	6.4	7.8
290	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.2880	4.4	5.6
291	Yes	No	05	MED	HEART FAILURE & SHOCK W MCC	1.4882	4.8	6.2
292	Yes	No	05	MED	HEART FAILURE & SHOCK W CC	1.0245	4.0	4.9
293	Yes	No	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6810	2.8	3.3
294	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0394	4.4	5.4
295	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6356	3.4	4.0
296	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.1698	1.8	2.8
297	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6844	1.4	1.8
298	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4523	1.1	1.2
299	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4050	4.7	6.1
300	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9737	3.9	4.9
301	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6579	2.8	3.5
302	No	No	05	MED	ATHEROSCLEROSIS W MCC	0.9712	3.0	4.0
303	No	No	05	MED	ATHEROSCLEROSIS W/O MCC	0.5804	2.0	2.4
304	No	No	05	MED	HYPERTENSION W MCC	1.0182	3.5	4.5
305	No	No	05	MED	HYPERTENSION W/O MCC	0.6117	2.2	2.7
306	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4681	4.4	5.9
307	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7927	2.7	3.4
308	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2270	4.0	5.2
309	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8331	3.0	3.7
310	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5670	2.1	2.5
311	No	No	05	MED	ANGINA PECTORIS	0.5038	1.8	2.2
312	No	No	05	MED	SYNCOPE & COLLAPSE	0.7136	2.4	2.9
313	No	No	05	MED	CHEST PAIN	0.5481	1.7	2.1
314	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.8232	5.0	6.9
315	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9645	3.3	4.2
316	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6124	2.1	2.6
326	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.8087	12.6	16.3
327	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.7293	6.9	8.8
328	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.4363	2.9	3.8
329	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.2995	12.5	15.4
330	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5865	7.8	9.1
331	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6299	4.8	5.3
332	Yes	No	06	SURG	RECTAL RESECTION W MCC	4.8539	11.8	14.2
333	Yes	No	06	SURG	RECTAL RESECTION W CC	2.5015	7.1	8.1
334	Yes	No	06	SURG	RECTAL RESECTION W/O CC/MCC	1.5980	4.2	4.9
335	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.2742	11.4	13.7
336	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3459	7.2	8.8
337	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4851	4.0	5.1
338	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.2121	8.3	10.0
339	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG	1.8691	5.6	6.5

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W CC			
340	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2447	3.2	3.7
341	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2602	4.9	6.6
342	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3301	3.0	3.8
343	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9636	1.7	2.0
344	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.1533	8.9	11.2
345	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6999	6.0	7.0
346	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1887	4.2	4.6
347	No	No	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4021	6.3	8.8
348	No	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3720	4.1	5.4
349	No	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.7996	2.3	2.9
350	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4467	5.6	7.8
351	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.3581	3.5	4.5
352	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8651	1.9	2.4
353	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.7608	6.3	8.4
354	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.5574	4.0	5.0
355	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.0383	2.3	2.8
356	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	4.0301	9.2	12.7
357	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1501	5.7	7.4
358	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3042	3.0	4.0
368	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.7585	5.1	6.7
369	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0755	3.7	4.5
370	No	No	06	MED	MAJOR ESOPHAGEAL	0.7497	2.6	3.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DISORDERS W/O CC/MCC			
371	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	2.0998	6.8	8.9
372	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2891	5.3	6.5
373	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8543	3.9	4.6
374	Yes	No	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0619	6.3	8.5
375	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.2773	4.4	5.8
376	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8405	2.8	3.6
377	Yes	No	06	MED	G.I. HEMORRHAGE W MCC	1.7496	5.0	6.4
378	Yes	No	06	MED	G.I. HEMORRHAGE W CC	1.0235	3.5	4.2
379	Yes	No	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7107	2.6	3.0
380	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9498	5.8	7.5
381	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W CC	1.1172	3.9	4.8
382	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8117	2.9	3.5
383	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.1936	4.2	5.3
384	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8308	3.0	3.6
385	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.9145	6.3	8.4
386	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0439	4.2	5.3
387	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7775	3.2	3.9
388	Yes	No	06	MED	G.I. OBSTRUCTION W MCC	1.6490	5.5	7.2
389	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9323	3.9	4.8
390	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6361	2.8	3.3
391	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.1553	3.9	5.2
392	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7152	2.8	3.4
393	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6569	4.9	6.9
394	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9917	3.7	4.7
395	No	No	06	MED	OTHER DIGESTIVE SYSTEM	0.6717	2.5	3.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSES W/O CC/MCC			
405	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.6074	12.0	15.9
406	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7826	6.5	8.4
407	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8691	4.2	5.2
408	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.9590	11.0	13.5
409	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.4837	7.4	8.9
410	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6208	4.9	5.8
411	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.6953	9.9	11.8
412	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.5380	7.0	8.3
413	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.7385	4.5	5.4
414	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6719	9.3	11.4
415	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.1000	6.2	7.3
416	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3123	3.7	4.4
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.5055	6.2	7.8
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7047	4.4	5.4
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1754	2.4	3.0
420	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.6914	9.2	13.1
421	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.8890	5.1	7.0
422	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.2777	3.1	4.1
423	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.4476	10.9	14.4
424	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.4219	7.1	9.1
425	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.6265	4.5	5.7
432	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.6939	4.9	6.5
433	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9487	3.6	4.6
434	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6116	2.5	3.2
435	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.8035	5.6	7.4
436	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.2175	4.2	5.5
437	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8973	2.8	3.7
438	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.8265	5.4	7.5
439	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	1.0081	4.0	5.0
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6878	2.9	3.5
441	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8335	5.2	7.1
442	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9843	3.7	4.8
443	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6578	2.7	3.3
444	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.5571	4.8	6.2
445	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0681	3.6	4.5
446	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7404	2.5	3.1
453	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.3048	10.7	13.5
454	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.3001	5.5	6.8
455	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL	5.4796	3.1	3.8

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					FUSION W/O CC/MCC			
456	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	9.2948	10.8	13.5
457	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.2478	5.9	7.0
458	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	4.9778	3.5	4.1
459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.5382	7.4	9.1
460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.9004	3.3	3.9
461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9653	6.7	8.3
462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3634	3.7	4.1
463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	4.9853	11.1	15.1
464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8664	6.9	8.9
465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7885	4.1	5.3
466	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.9381	7.3	9.0
467	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.2568	4.3	5.0
468	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5912	3.3	3.6
469	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.4827	6.7	8.0
470	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.1173	3.4	3.7
471	No	No	08	SURG	CERVICAL SPINAL FUSION W MCC	4.7410	6.6	9.3
472	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.7945	2.6	3.8
473	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0987	1.5	1.9
474	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.5131	9.2	12.0
475	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9640	6.1	7.7
476	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	0.9985	3.2	4.1
477	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.3163	8.9	11.1
478	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2598	5.3	6.9
479	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.6417	2.4	3.4
480	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0913	7.7	9.0
481	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.8944	5.1	5.6
482	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5431	4.1	4.5
483	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.4235	3.1	3.7
484	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.9713	2.0	2.2
485	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.1808	9.0	10.9
486	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0450	6.1	7.2
487	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4752	4.4	5.1
488	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.7294	3.8	4.7
489	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2220	2.5	2.9
490	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7996	3.0	4.3
491	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	0.9982	1.7	2.1
492	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.0748	6.8	8.6
493	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR	1.8573	4.2	5.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W CC			
494	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.3220	2.7	3.1
495	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8691	7.6	10.2
496	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6275	4.1	5.4
497	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0813	2.0	2.6
498	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9968	5.4	7.3
499	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.9936	2.2	3.0
500	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0486	7.7	10.5
501	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5858	4.6	6.0
502	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.0354	2.3	2.8
503	No	No	08	SURG	FOOT PROCEDURES W MCC	2.2681	6.5	8.4
504	No	No	08	SURG	FOOT PROCEDURES W CC	1.5696	5.0	6.2
505	No	No	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.0792	2.5	3.1
506	No	No	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1834	2.7	3.8
507	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.8823	3.4	4.5
508	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4101	1.7	2.1
509	No	No	08	SURG	ARTHROSCOPY	1.3044	2.3	3.5
510	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.1698	5.0	6.3
511	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.4748	3.2	3.9
512	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0533	1.8	2.1
513	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.3000	3.5	4.8
514	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.8215	2.1	2.6
515	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.1992	7.7	9.9
516	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9292	4.7	5.9
517	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.4856	2.6	3.4
533	Yes	No	08	MED	FRACTURES OF FEMUR W MCC	1.5545	4.9	6.5
534	Yes	No	08	MED	FRACTURES OF FEMUR W/O MCC	0.7576	3.1	3.9
535	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.3495	4.5	5.8
536	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7175	3.2	3.7
537	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8242	3.5	4.1
538	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.6060	2.6	3.0
539	Yes	No	08	MED	OSTEOMYELITIS W MCC	2.0525	7.1	9.5
540	Yes	No	08	MED	OSTEOMYELITIS W CC	1.3139	5.4	6.8
541	Yes	No	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8733	3.7	4.8
542	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.9499	6.3	8.3
543	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1564	4.5	5.6
544	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7753	3.4	4.0
545	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.5453	6.3	9.0
546	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1596	4.2	5.3
547	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7297	2.9	3.5
548	No	No	08	MED	SEPTIC ARTHRITIS W MCC	1.9836	6.6	8.7
549	No	No	08	MED	SEPTIC ARTHRITIS W CC	1.2003	4.8	6.1
550	No	No	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.8223	3.3	4.0
551	Yes	No	08	MED	MEDICAL BACK PROBLEMS W MCC	1.6337	5.2	6.8
552	Yes	No	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.8160	3.3	4.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
553	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.1369	4.3	5.6
554	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6774	3.0	3.6
555	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.0941	3.6	4.8
556	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6536	2.5	3.2
557	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.5997	5.4	6.9
558	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8796	3.6	4.3
559	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7624	5.2	7.1
560	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	0.9992	3.6	4.6
561	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.6201	2.0	2.6
562	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3925	4.5	5.9
563	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.7120	3.0	3.6
564	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4686	5.0	6.6
565	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9051	3.7	4.6
566	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6592	2.7	3.4
573	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	3.2654	9.2	12.6
574	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.8708	6.7	8.5
575	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.0915	4.2	5.2
576	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.9309	9.1	13.0
577	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	1.7025	4.1	6.2
578	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0505	2.4	3.3
579	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.9643	7.7	10.5
580	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4993	3.8	5.4
581	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.9301	1.8	2.4
582	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.0633	2.0	2.7
583	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.8543	1.5	1.7
584	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.5258	3.5	5.0
585	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.0568	1.7	2.1
592	Yes	No	09	MED	SKIN ULCERS W MCC	1.7757	6.2	8.3
593	Yes	No	09	MED	SKIN ULCERS W CC	1.0631	4.8	5.9
594	Yes	No	09	MED	SKIN ULCERS W/O CC/MCC	0.7550	3.6	4.7
595	No	No	09	MED	MAJOR SKIN DISORDERS W MCC	1.8752	5.9	7.9
596	No	No	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8700	3.7	4.6
597	No	No	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.5651	5.5	7.5
598	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0728	4.1	5.5
599	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6318	2.5	3.3
600	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9639	4.1	4.9
601	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6731	3.0	3.6
602	Yes	No	09	MED	CELLULITIS W MCC	1.4705	5.3	6.7
603	Yes	No	09	MED	CELLULITIS W/O MCC	0.8346	3.8	4.5
604	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.2286	3.9	5.2
605	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.7145	2.7	3.3
606	No	No	09	MED	MINOR SKIN DISORDERS W MCC	1.3114	4.3	6.0
607	No	No	09	MED	MINOR SKIN DISORDERS W/O	0.6803	2.8	3.6

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					MCC			
614	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURFS W CC/MCC	2.4584	4.7	6.5
615	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.3993	2.5	3.0
616	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.4871	12.5	15.6
617	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0083	6.5	7.9
618	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.2176	4.1	5.1
619	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.6116	4.6	7.7
620	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8814	2.6	3.4
621	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4877	1.6	1.9
622	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.3683	9.4	12.4
623	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8501	6.1	7.6
624	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.0337	3.9	4.8
625	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2439	4.6	6.9
626	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1771	2.1	3.1
627	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.7884	1.2	1.4
628	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.3820	7.2	10.6
629	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.2645	6.5	8.0
630	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.4425	3.4	4.5
637	Yes	No	10	MED	DIABETES W MCC	1.4431	4.5	6.0
638	Yes	No	10	MED	DIABETES W CC	0.8267	3.2	4.0
639	Yes	No	10	MED	DIABETES W/O CC/MCC	0.5508	2.3	2.8
640	Yes	No	10	MED	NUTRITIONAL & MISC	1.1361	3.6	5.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					METABOLIC DISORDERS W MCC			
641	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	0.6887	2.9	3.6
642	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0385	3.4	4.7
643	Yes	No	10	MED	ENDOCRINE DISORDERS W MCC	1.8172	6.0	7.6
644	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0586	4.2	5.2
645	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7169	2.9	3.6
652	No	No	11	SURG	KIDNEY TRANSPLANT	3.0630	6.3	7.5
653	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W MCC	6.0950	13.6	16.6
654	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W CC	3.0117	8.2	9.3
655	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9644	4.8	5.7
656	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.5861	7.7	10.1
657	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	2.0062	4.9	5.9
658	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.4305	3.0	3.4
659	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.5110	8.0	10.8
660	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.9077	4.5	6.0
661	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2709	2.4	2.9
662	No	No	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.0413	7.6	10.8
663	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4721	3.6	5.2
664	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1170	1.5	1.9
665	No	No	11	SURG	PROSTATECTOMY W MCC	2.8519	8.7	11.3
666	No	No	11	SURG	PROSTATECTOMY W CC	1.6440	4.5	6.4
667	No	No	11	SURG	PROSTATECTOMY W/O CC/MCC	0.7945	1.8	2.4
668	No	No	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.5102	6.6	8.9
669	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2610	3.2	4.4

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
670	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7790	1.8	2.3
671	No	No	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.4360	4.1	5.6
672	No	No	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.7921	1.8	2.2
673	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9238	5.9	9.6
674	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.1004	4.6	6.7
675	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3469	1.6	2.1
682	Yes	No	11	MED	RENAL FAILURE W MCC	1.6383	5.1	6.8
683	Yes	No	11	MED	RENAL FAILURE W CC	1.0208	4.0	4.9
684	Yes	No	11	MED	RENAL FAILURE W/O CC/MCC	0.6561	2.8	3.3
685	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8892	2.5	3.4
686	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.8264	5.8	7.8
687	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0822	3.8	5.0
688	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6447	2.2	2.8
689	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.2155	4.6	5.8
690	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7838	3.4	4.1
691	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6152	3.3	4.3
692	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1211	1.8	2.2
693	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3487	3.9	5.2
694	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7098	2.0	2.6
695	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2029	4.3	5.6
696	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6555	2.6	3.2
697	No	No	11	MED	URETHRAL STRICTURE	0.7776	2.4	3.1
698	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6033	5.2	6.8
699	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9988	3.7	4.7
700	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6703	2.6	3.2
707	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7846	3.2	4.2
708	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2691	1.6	1.9
709	No	No	12	SURG	PENIS PROCEDURES W CC/MCC	1.8781	3.3	5.7
710	No	No	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.2779	1.4	1.7
711	No	No	12	SURG	TESTES PROCEDURES W CC/MCC	1.7619	5.1	7.3
712	No	No	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.8121	2.1	2.7
713	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.1836	2.9	4.1
714	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.6583	1.6	1.8
715	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7470	4.1	6.1
716	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.0022	1.2	1.4
717	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6076	4.6	6.4
718	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.8033	2.0	2.6
722	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6785	5.4	7.7
723	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.0170	3.9	5.1
724	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6171	2.0	2.7
725	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2620	4.6	6.1
726	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.6977	2.8	3.5
727	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3582	4.9	6.3
728	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7599	3.3	4.1
729	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.9802	3.6	4.7
730	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6377	2.3	2.8
734	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.4243	5.1	6.9

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
735	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.1801	2.2	2.7
736	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.3876	11.5	14.0
737	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0407	5.7	6.7
738	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.2377	3.2	3.6
739	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.4188	7.5	9.9
740	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5323	3.8	4.7
741	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.1068	2.2	2.6
742	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3971	3.2	4.1
743	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.9150	1.8	2.1
744	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.5367	4.0	5.6
745	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.8077	1.9	2.4
746	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.3373	3.0	4.2
747	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.8929	1.5	1.8
748	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9231	1.4	1.7
749	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5219	6.2	8.5
750	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0.9389	2.2	2.8
754	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	2.0061	6.4	8.8
755	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1371	4.0	5.3
756	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6370	2.3	3.1
757	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.6490	6.0	7.8
758	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0895	4.7	5.7
759	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7344	3.3	4.0
760	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8298	2.9	3.8
761	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5246	1.8	2.2
765	No	No	14	SURG	CESAREAN SECTION W CC/MCC	1.1316	3.9	4.9
766	No	No	14	SURG	CESAREAN SECTION W/O CC/MCC	0.8063	2.9	3.1
767	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.9173	2.4	2.7
768	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.8108	0.0	0.0
769	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2.0588	3.6	5.7
770	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7140	1.6	2.1
774	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6894	2.6	3.2
775	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5276	2.1	2.3
776	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6419	2.6	3.3
777	No	No	14	MED	ECTOPIC PREGNANCY	0.7401	1.7	2.1
778	No	No	14	MED	THREATENED ABORTION	0.4880	2.0	3.2
779	No	No	14	MED	ABORTION W/O D&C	0.5637	1.6	2.1
780	No	No	14	MED	FALSE LABOR	0.2277	1.2	1.6
781	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6807	2.7	3.8
782	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4731	1.9	2.6
789	No	No	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4874	0.0	0.0
790	No	No	15	MED	EXTREME IMMATURITY OR	4.9049	0.0	0.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					RESPIRATORY DISTRESS SYNDROME, NEONATE			
791	No	No	15	MED	PREMATURITY W MAJOR PROBLEMS	3.3499	0.0	0.0
792	No	No	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.0213	0.0	0.0
793	No	No	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.4411	0.0	0.0
794	No	No	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.2179	0.0	0.0
795	No	No	15	MED	NORMAL NEWBORN	0.1649	0.0	0.0
799	No	No	16	SURG	SPLENECTOMY W MCC	4.9483	10.4	13.4
800	No	No	16	SURG	SPLENECTOMY W CC	2.6030	5.9	7.5
801	No	No	16	SURG	SPLENECTOMY W/O CC/MCC	1.5588	3.1	3.9
802	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.6327	8.6	12.2
803	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.8899	4.9	6.5
804	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0419	2.3	3.0
808	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1429	6.3	8.2
809	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1935	4.0	5.1
810	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9204	3.0	3.7
811	No	No	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2574	3.9	5.3
812	No	No	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.7996	2.8	3.7
813	No	No	16	MED	COAGULATION DISORDERS	1.4355	3.6	5.0
814	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6466	5.0	6.9
815	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9989	3.6	4.6
816	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6826	2.6	3.2
820	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.7484	13.2	17.5
821	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3960	5.3	7.4
822	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2251	2.3	3.1
823	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	4.5904	12.2	16.0
824	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.3004	6.6	8.7
825	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2439	2.7	3.9
826	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.8575	11.2	14.8
827	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.1547	5.3	6.9
828	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.3894	3.0	3.8
829	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.7281	6.2	9.3
830	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	1.0911	2.3	3.1
834	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	4.9043	10.1	16.2
835	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.4310	5.7	9.3
836	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.1364	3.0	4.4
837	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.6543	17.9	23.6
838	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.1384	8.1	12.3
839	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2874	4.6	5.7
840	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	2.9245	7.8	10.6
841	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6376	5.1	6.8
842	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.0382	3.2	4.2
843	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W	1.8400	6.0	8.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					MCC			
844	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1895	4.3	5.6
845	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8099	2.9	3.8
846	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.1885	5.4	8.0
847	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	0.9901	2.8	3.4
848	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.8070	2.4	3.0
849	No	No	17	MED	RADIOTHERAPY	1.2501	4.4	6.0
853	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.5154	12.1	15.7
854	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.7976	8.2	10.0
855	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.3920	3.9	5.4
856	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	5.1335	11.2	15.0
857	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.1011	6.2	7.9
858	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3079	4.1	5.1
862	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.9553	5.8	7.8
863	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9765	4.0	4.9
864	No	No	18	MED	FEVER	0.8255	3.0	3.8
865	No	No	18	MED	VIRAL ILLNESS W MCC	1.5524	4.5	6.4
866	No	No	18	MED	VIRAL ILLNESS W/O MCC	0.7420	2.8	3.5
867	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.4723	6.8	9.2
868	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES	1.1597	4.3	5.4

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSES W CC			
869	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7183	3.0	3.6
870	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8105	12.8	15.2
871	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.9056	5.4	7.2
872	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1522	4.5	5.4
876	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.8176	8.1	12.7
880	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6148	2.3	3.0
881	No	No	19	MED	DEPRESSIVE NEUROSES	0.6140	3.1	4.2
882	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6250	3.1	4.3
883	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.0741	4.9	7.7
884	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9345	4.0	5.4
885	No	No	19	MED	PSYCHOSES	0.8920	5.4	7.4
886	No	No	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.8253	3.9	6.2
887	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.7744	2.9	4.0
894	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4007	2.1	2.9
895	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.0145	8.5	10.9
896	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.4528	4.7	6.5
897	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6413	3.2	4.0
901	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	3.9427	9.1	14.1
902	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7989	5.4	7.5
903	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0616	3.3	4.4
904	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.0388	7.3	11.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
905	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.1720	3.4	4.5
906	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	1.0393	2.1	3.1
907	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8155	7.8	11.1
908	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9277	4.7	6.3
909	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1622	2.6	3.4
913	No	No	21	MED	TRAUMATIC INJURY W MCC	1.3305	4.0	5.6
914	No	No	21	MED	TRAUMATIC INJURY W/O MCC	0.6943	2.5	3.2
915	No	No	21	MED	ALLERGIC REACTIONS W MCC	1.4162	3.6	5.1
916	No	No	21	MED	ALLERGIC REACTIONS W/O MCC	0.4820	1.7	2.1
917	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4814	3.7	5.1
918	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.6234	2.1	2.7
919	No	No	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.5999	4.4	6.2
920	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9760	3.2	4.3
921	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6179	2.2	2.8
922	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.3409	3.8	5.4
923	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6742	2.3	3.2
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.6506	21.8	28.2
928	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.7191	10.8	14.9
929	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.0261	5.3	7.7
933	No	No	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.2750	2.3	5.2
934	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3530	4.1	5.8
935	No	No	22	MED	NON-EXTENSIVE BURNS	1.2817	3.5	5.2
939	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	2.8683	6.8	10.0
940	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.6847	3.6	5.4
941	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1488	2.0	2.6
945	Yes	No	23	MED	REHABILITATION W CC/MCC	1.2883	8.3	10.2
946	Yes	No	23	MED	REHABILITATION W/O CC/MCC	1.1140	6.6	7.5
947	Yes	No	23	MED	SIGNS & SYMPTOMS W MCC	1.0970	3.7	4.9
948	Yes	No	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6840	2.7	3.4
949	No	No	23	MED	AFTERCARE W CC/MCC	0.9823	2.6	4.3
950	No	No	23	MED	AFTERCARE W/O CC/MCC	0.4983	2.1	2.8
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.6963	2.2	4.5
955	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4991	9.0	12.6
956	Yes	No	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.3461	7.0	8.4
957	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.3035	10.2	14.3
958	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.8041	7.6	9.5
959	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.2479	4.5	5.6
963	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.8145	6.0	8.7
964	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4818	4.5	5.6
965	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9316	3.1	3.8
969	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5054	12.1	17.1
970	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7380	6.3	8.7
974	No	No	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.5819	6.9	9.6
975	No	No	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3551	5.1	6.6
976	No	No	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9004	3.5	4.4
977	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0398	3.6	4.9
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0726	11.0	14.1
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL	2.9434	6.8	8.7

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSIS W CC			
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.7800	3.1	4.2
984	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3086	10.5	13.3
985	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.1518	6.9	9.0
986	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1129	2.8	4.1
987	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.4500	9.3	12.2
988	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.8721	5.6	7.4
989	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0568	2.5	3.5
998	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
999	No	No		**	UNGROUPABLE	0.0000	0.0	0.0

MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.
Note: If there is no value in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to determine a meaningful computation of these statistics.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
237.73	Schwannomatosis	N	01	091,092,093
237.78	Other neurofibromatosis	N	01	091,092,093
275.01	Hereditary hemochromatosis	N	10	642
275.02	Hemochromatosis due to repeated red blood cell transfusions	N	10	642
275.03	Other hemochromatosis	N	10	642
275.09	Other disorders of iron metabolism	N	10	642
276.61	Transfusion associated circulatory overload	N	10 15	640,641 791[1],793[1]
276.69	Other fluid overload	N	10 15	640,641 791[1],793[1]
278.03	Obesity hypoventilation syndrome	N	04	205,206
287.41	Posttransfusion purpura	N	15 16 25	791[1],793[1] 813 977
287.49	Other secondary thrombocytopenia	N	15 16 25	791[1],793[1] 813 977
447.70	Aortic ectasia, unspecified site	N	05	299,300,301
447.71	Thoracic aortic ectasia	N	05	299,300,301
447.72	Abdominal aortic ectasia	N	05	299,300,301
447.73	Thoracoabdominal aortic ectasia	N	05	299,300,301
560.32	Fecal impaction	N	06 15	388,389,390 791[1],793[1]
724.03	Spinal stenosis, lumbar region, with neurogenic claudication	N	08	551,552
752.31	Agenesis of uterus	N	13	742,743,760,761
752.32	Hypoplasia of uterus	N	13	742,743,760,761
752.33	Unicornuate uterus	N	13	742,743,760,761
752.34	Bicornuate uterus	N	13	742,743,760,761
752.35	Septate uterus	N	13	742,743,760,761
752.36	Arcuate uterus	N	13	742,743,760,761
752.39	Other anomalies of uterus	N	13	742,743,760,761
752.43	Cervical agenesis	N	13	742,743,760,761
752.44	Cervical duplication	N	13	742,743,760,761
752.45	Vaginal agenesis	N	13	742,743,760,761

Diagnosis Code	Description	CC	MDC	MS-DRG
752.46	Transverse vaginal septum	N	13	742,743,760,761
752.47	Longitudinal vaginal septum	N	13	742,743,760,761
780.33	Post traumatic seizures	N	01	100,101
780.66	Febrile nonhemolytic transfusion reaction	N	18 25	864 977
784.92	Jaw pain	N	PRE 03	011,012,013 157,158,159
786.30	Hemoptysis, unspecified	CC	04	204
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]	CC	04	204
786.39	Other hemoptysis	CC	04	204
787.60	Full incontinence of feces	N	06	391,392
787.61	Incomplete defecation	N	06	391,392
787.62	Fecal smearing	N	06	391,392
787.63	Fecal urgency	N	06	391,392
799.50	Unspecified signs and symptoms involving cognition	N	19	884
799.51	Attention or concentration deficit	N	19	886
799.52	Cognitive communication deficit	N	19	884
799.53	Visuospatial deficit	N	01	091,092,093
799.54	Psychomotor deficit	N	19	884
799.55	Frontal lobe and executive function deficit	N	19	884
799.59	Other signs and symptoms involving cognition	N	19	884
970.81	Poisoning by cocaine	N	21	917,918
970.89	Poisoning by other central nervous system stimulants	N	21	917,918
999.60	ABO incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.62	ABO incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.69	Other ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.70	Rh incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.72	Rh incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.73	Rh incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.74	Other Rh incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.75	Non-ABO incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.79	Other non-ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.80	Transfusion reaction, unspecified	N	15 16	791[1],793[1] 811,812
999.83	Hemolytic transfusion reaction, incompatibility unspecified	CC	15 16	791[1],793[1] 811,812
999.84	Acute hemolytic transfusion reaction, incompatibilty unspecified	CC	15 16	791[1],793[1] 811,812
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified	CC	15 16	791[1],793[1] 811,812
V11.4	Personal history of combat and operational stress reaction	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
V13.23	Personal history of vaginal dysplasia	N	23	951
V13.24	Personal history of vulvar dysplasia	N	23	951
V13.62	Personal history of other (corrected) congenital malformations of genitourinary system	N	23	951
V13.63	Personal history of (corrected) congenital malformations of nervous system	N	23	951
V13.64	Personal history of (corrected) congenital malformations of eye, ear, face and neck	N	23	951
V13.65	Personal history of (corrected) congenital malformations of heart and circulatory system	N	23	951
V13.66	Personal history of (corrected) congenital malformations of respiratory system	N	23	951
V13.67	Personal history of (corrected) congenital malformations of digestive system	N	23	951
V13.68	Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal system	N	23	951
V15.53	Personal history of retained foreign body fully removed	N	23	951
V25.11	Encounter for insertion of intrauterine contraceptive device	N	23	951
V25.12	Encounter for removal of intrauterine contraceptive device	N	23	951
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device	N	23	951
V49.86	Do not resuscitate status	N	23	951
V62.85	Homicidal ideation	N	23	951
V85.41	Body Mass Index 40.0-44.9, adult	CC	10	640,641
V85.42	Body Mass Index 45.0-49.9, adult	CC	10	640,641
V85.43	Body Mass Index 50.0-59.9, adult	CC	10	640,641
V85.44	Body Mass Index 60.0-69.9, adult	CC	10	640,641
V85.45	Body Mass Index 70 and over, adult	CC	10	640,641
V88.11	Acquired total absence of pancreas	N	23	951
V88.12	Acquired partial absence of pancreas	N	23	951
V90.01	Retained depleted uranium fragments	N	23	951
V90.09	Other retained radioactive fragments	N	23	951
V90.10	Retained metal fragments, unspecified	N	23	951
V90.11	Retained magnetic metal fragments	N	23	951
V90.12	Retained nonmagnetic metal fragments	N	23	951
V90.2	Retained plastic fragments	N	23	951
V90.31	Retained animal quills or spines	N	23	951
V90.32	Retained tooth	N	23	951
V90.33	Retained wood fragments	N	23	951
V90.39	Other retained organic fragments	N	23	951
V90.81	Retained glass fragments	N	23	951
V90.83	Retained stone or crystalline fragments	N	23	951
V90.89	Other specified retained foreign body	N	23	951
V90.9	Retained foreign body, unspecified material	N	23	951
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs	N	23	951
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)	N	23	951
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)	N	23	951
V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)	N	23	951
V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.10	Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.11	Triplet gestation, with two or more monochorionic fetuses	N	23	951
V91.12	Triplet gestation, with two or more monoamniotic fetuses	N	23	951
V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.20	Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.21	Quadruplet gestation, with two or more monochorionic fetuses	N	23	951
V91.22	Quadruplet gestation, with two or more monoamniotic fetuses	N	23	951
V91.29	Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.91	Other specified multiple gestation, with two or more monochorionic fetuses	N	23	951
V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses	N	23	951
V91.99	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951

Notes:
[1] Secondary diagnosis of major problem

TABLE 6B.—NEW PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.60	Insertion of drug-eluting stent(s) of superficial femoral artery	N		
32.27	Bronchoscopic bronchial thermoplasty, ablation of airway smooth muscle	Y	04	163,164,165
39.81	Implantation or replacement of carotid sinus stimulation device, total system	Y	05	252,253,254
39.82	Implantation or replacement of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.83	Implantation or replacement of carotid sinus stimulation pulse generator only	Y	05	252,253,254
39.84	Revision of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.85	Revision of carotid sinus stimulation pulse generator	Y	05	252,253,254
39.86	Removal of carotid sinus stimulation device, total system	Y	05	252,253,254
39.87	Removal of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.88	Removal of carotid sinus stimulation pulse generator only	Y	05	252,253,254
39.89	Other operations on carotid body, carotid sinus and other vascular bodies	Y	05	252,253,254
81.88	Reverse total shoulder replacement	Y	08 21 24	483,484 907,908,909 957,958,959

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
275.0	Disorders of iron metabolism	N	10	642
276.6	Fluid overload	N	10 15	640,641 791[1],793[1]
287.4	Secondary thrombocytopenia	N	15 16 25	791[1],793[1] 813 977
752.3	Other anomalies of uterus	N	13	742,743,760,761
786.3	Hemoptysis	CC	04	204
787.6	Incontinence of feces	N	06	391,392
970.8	Poisoning by other specified central nervous system stimulants	N	21	917,918
999.6	ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.7	Rh incompatibility reaction	CC	15 16	791[1],793[1] 811,812
V25.1	Encounter for insertion of intrauterine contraceptive device	N	23	951
V85.4	Body Mass Index 40 and over, adult	CC	10	640,641

Notes:
[1] Secondary diagnosis of major problem

TABLE 6D.—INVALID PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
39.8	Operations on carotid body, carotid sinus and other vascular bodies	Y	01 04 05	037,038,039 166,167,168 252,253,254

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	MS-DRG
629.81	Recurrent pregnancy loss without current pregnancy	N	13	742,743,760,761
646.30	Recurrent pregnancy loss, unspecified as to episode of care or not applicable	N	14	998
646.31	Recurrent pregnancy loss, delivered, with or without mention of antepartum condition	CC	14	765,766,767,768,774, 775
646.33	Recurrent pregnancy loss, antepartum condition or complication	N	14	781,782
724.02	Spinal stenosis, lumbar region, without neurogenic claudication	N	08	551,552
781.8	Neurologic neglect syndrome	CC	01	091,092,093
V13.61	Personal history of (corrected) hypospadias	N	23	951
V13.69	Personal history of other (corrected) congenital malformations	N	23	951
V26.35	Encounter for testing of male partner of female with recurrent pregnancy loss	N	23	951

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.55	Insertion of drug-eluting stent(s) of other peripheral vessel(s)	N		
81.80	Other total shoulder replacement	Y	08 21 24	483,484 907,908,909 957,958,959
99.14	Injection or infusion of immunoglobulin	N		

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGHTS OF STAY; FY 2009 MedPAR UPDATE – DECEMBER 2009 GROUPER V27.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	1,001	40.5395	12	19	31	50	80
2	239	20.7113	8	11	15	26	39
3	21,956	36.6115	15	21	30	44	63
4	21,395	27.1269	11	16	22	32	46
5	949	19.6185	6	9	14	24	41
6	348	8.3937	5	6	8	10	12
7	469	18.7058	8	11	15	23	31
8	508	11.7835	6	7	9	13	21
9	1,818	21.3311	8	15	19	25	33
10	137	9.7007	5	7	8	11	13
11	1,534	15.5782	6	8	12	19	29
12	1,895	9.9135	4	6	8	12	17
13	1,008	6.7401	3	4	6	8	11
20	1,102	17.1207	6	10	16	23	29
21	448	13.9866	7	10	14	17	22
22	146	8.3767	2	4	8	12	14
23	4,479	11.7948	2	5	9	16	23
24	1,635	7.8526	1	3	6	10	15
25	12,006	11.4943	3	6	9	15	22
26	11,045	7.2149	2	4	6	9	13
27	12,591	3.8861	1	2	3	5	7
28	1,983	13.0479	4	7	11	16	24
29	3,373	6.3409	1	3	5	8	12
30	3,432	3.2797	1	1	3	4	7
31	1,247	12.0938	2	5	9	16	24
32	2,730	5.2289	1	2	4	7	11
33	3,351	2.6640	1	1	2	3	5
34	976	6.9191	1	2	6	9	14
35	2,179	2.9849	1	1	2	4	7
36	5,732	1.5223	1	1	1	1	3
37	5,691	8.2903	2	3	7	11	17
38	13,702	3.3307	1	1	2	4	8
39	43,823	1.6743	1	1	1	2	3
40	5,628	11.7386	3	6	9	15	22
41	6,741	6.3600	1	3	5	8	12
42	3,808	3.2261	1	1	2	4	7
52	1,250	6.6328	2	3	5	7	11
53	487	3.5832	1	2	3	5	6
54	7,691	6.2942	2	3	5	8	12
55	12,545	4.5368	1	2	3	6	9
56	11,620	6.9885	2	3	5	8	13
57	40,900	4.7691	2	3	4	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
58	1,005	7.0537	2	3	5	8	13
59	3,138	4.9143	2	3	4	6	8
60	3,515	3.7713	1	2	3	5	6
61	2,468	8.2265	2	4	7	11	16
62	3,537	5.5785	2	3	5	7	10
63	1,309	3.9152	2	2	3	5	7
64	70,612	6.7735	2	3	5	9	13
65	102,945	4.7452	2	3	4	6	8
66	66,535	3.2734	1	2	3	4	6
67	1,959	5.2409	2	3	4	6	9
68	9,804	3.2279	1	2	3	4	6
69	92,535	2.7913	1	2	2	3	5
70	12,885	7.0182	2	3	5	9	13
71	10,469	4.8679	2	3	4	6	9
72	4,838	3.1174	1	2	2	4	6
73	11,890	5.5112	2	3	4	7	10
74	28,604	3.9747	1	2	3	5	7
75	1,348	6.9733	2	4	5	8	13
76	661	3.9259	1	2	3	5	7
77	1,834	6.4002	2	3	5	8	12
78	1,807	4.0697	1	2	3	5	7
79	774	3.0749	1	2	3	4	5
80	2,027	4.8101	1	2	4	6	9
81	5,465	3.3420	1	2	3	4	6
82	2,546	6.0361	1	1	4	8	13
83	2,422	4.5727	1	2	3	6	9
84	2,542	2.7825	1	1	2	4	5
85	8,441	6.9889	2	3	5	9	14
86	13,175	4.5672	1	2	4	6	8
87	13,012	2.9085	1	1	2	4	5
88	1,078	5.3497	2	3	4	7	10
89	2,947	3.6339	1	2	3	5	7
90	2,481	2.3136	1	1	2	3	4
91	10,887	6.0043	2	3	4	7	12
92	17,603	4.0852	1	2	3	5	7
93	13,215	2.8862	1	1	2	4	5
94	1,527	11.7394	3	6	10	15	21
95	1,085	8.1779	3	5	7	10	15
96	540	5.6667	1	4	5	7	10
97	1,324	11.4373	4	6	9	15	21
98	928	7.6185	3	4	6	10	13
99	423	5.1915	2	3	4	7	10
100	21,435	5.8217	2	3	4	7	11
101	53,878	3.3892	1	2	3	4	6
102	1,501	4.2205	1	2	3	5	9
103	12,310	3.0085	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
113	639	5.5994	1	2	4	7	11
114	431	2.5986	1	1	2	3	5
115	850	4.6082	1	2	4	5	7
116	455	4.4813	1	1	2	5	7
117	549	1.9872	1	1	1	1	2
121	744	5.1022	2	3	4	6	8
122	524	3.9790	1	2	3	5	7
123	2,672	2.7182	1	1	2	3	5
124	975	5.1918	1	2	4	6	10
125	4,038	3.2590	1	2	3	4	6
129	1,508	5.2454	1	2	4	7	11
130	943	2.8908	1	1	2	4	6
131	1,132	5.5998	1	2	4	7	11
132	748	2.7126	1	1	2	3	5
133	2,242	5.3965	1	2	4	7	11
134	2,627	2.0837	1	1	1	2	4
135	466	6.3112	1	2	5	9	13
136	351	2.2422	1	1	1	3	5
137	891	4.9989	1	2	4	6	10
138	747	2.4873	1	1	2	3	5
139	1,363	1.7601	1	1	1	2	3
146	841	8.6992	2	4	7	11	18
147	1,255	5.6805	1	2	4	7	11
148	552	3.3442	1	1	2	4	6
149	33,609	2.6159	1	1	2	3	5
150	1,544	4.7668	1	2	4	6	9
151	5,784	2.7934	1	1	2	4	5
152	2,893	4.1912	1	2	3	5	8
153	10,870	3.0419	1	2	2	4	5
154	3,034	5.6839	1	3	4	7	11
155	5,578	4.1133	1	2	3	5	8
156	3,515	2.8942	1	1	2	4	5
157	1,703	6.3429	2	3	5	8	13
158	3,380	4.2719	1	2	3	5	8
159	1,459	2.7347	1	1	2	3	5
163	14,398	13.8007	5	8	12	18	25
164	17,845	7.2187	3	4	6	9	13
165	10,518	4.3993	2	3	4	6	7
166	25,172	11.8608	4	6	9	15	22
167	17,710	7.0035	2	4	6	9	13
168	4,388	4.2985	1	2	3	6	8
175	16,505	6.7183	3	4	6	8	11
176	34,233	4.8503	2	3	4	6	8
177	79,035	8.4026	3	4	7	11	15
178	60,900	6.6817	3	4	6	8	12
179	16,039	4.9675	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
180	22,329	7.4210	2	4	6	9	14
181	24,506	5.3350	1	2	4	7	10
182	2,840	3.6532	1	2	3	5	7
183	3,042	6.3534	2	3	5	8	12
184	4,806	4.2239	2	3	4	5	7
185	2,187	3.0393	1	2	3	4	5
186	11,691	6.7234	2	3	5	9	13
187	9,939	4.7687	1	2	4	6	9
188	3,293	3.5299	1	2	3	4	7
189	94,058	5.5455	2	3	4	7	10
190	150,776	5.4847	2	3	5	7	10
191	136,438	4.5856	2	3	4	6	8
192	134,412	3.6580	1	2	3	5	6
193	132,433	6.3110	2	3	5	8	11
194	178,528	4.8665	2	3	4	6	8
195	87,008	3.6926	1	2	3	5	6
196	7,608	6.8980	2	4	6	9	13
197	6,141	4.9870	2	3	4	6	9
198	3,047	3.7670	1	2	3	5	7
199	4,146	7.8968	2	4	6	10	15
200	8,319	4.6915	1	2	4	6	9
201	2,745	3.5457	1	2	3	5	7
202	38,888	4.1342	1	2	3	5	7
203	28,980	3.1588	1	2	3	4	6
204	23,390	2.7325	1	1	2	3	5
205	7,730	5.2508	1	2	4	7	10
206	18,931	3.1590	1	1	3	4	6
207	36,288	14.7898	6	9	13	18	25
208	74,965	7.0337	1	3	6	9	14
215	177	12.6215	1	3	8	14	28
216	10,499	16.8419	8	10	15	21	28
217	5,948	10.3763	6	7	9	13	16
218	1,222	7.9869	5	6	7	9	12
219	14,314	12.8291	5	7	10	15	23
220	15,334	7.7011	4	5	7	9	12
221	4,475	5.9678	4	5	6	7	9
222	3,308	11.6403	4	6	10	15	21
223	3,289	5.4472	1	2	5	8	11
224	3,018	9.6156	3	5	8	12	18
225	4,209	5.0663	2	3	4	7	9
226	8,959	7.9386	1	3	6	11	16
227	28,451	2.7800	1	1	1	4	7
228	2,564	13.9961	6	8	12	17	25
229	2,590	7.9672	4	5	7	10	13
230	806	5.5186	2	4	5	7	9
231	1,473	12.8758	6	8	11	16	22

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
232	1,098	9.0674	5	6	9	11	14
233	17,629	13.4855	7	9	12	16	22
234	25,101	8.6064	5	6	8	10	13
235	11,045	10.6010	5	6	9	13	18
236	23,925	6.3642	4	5	6	7	10
237	24,161	10.0501	2	4	8	13	20
238	37,998	3.9482	1	1	3	6	8
239	12,154	14.2365	5	7	11	18	27
240	9,506	9.1471	3	5	8	11	16
241	1,552	5.9852	2	3	5	8	11
242	23,571	7.7578	2	4	6	10	14
243	35,573	4.6588	1	2	4	6	9
244	44,828	2.8119	1	1	2	4	6
245	3,970	3.8071	1	1	2	5	8
246	35,016	5.0861	1	2	4	7	10
247	139,869	2.1763	1	1	2	3	4
248	16,308	6.0738	1	3	5	8	12
249	44,453	2.6377	1	1	2	3	5
250	9,062	6.9734	2	3	5	9	14
251	35,031	2.7814	1	1	2	4	6
252	45,083	8.0234	1	3	6	10	17
253	40,080	5.6453	1	2	4	7	11
254	38,370	2.6631	1	1	2	3	6
255	2,897	9.2444	3	5	8	12	17
256	2,782	6.6618	2	3	6	8	12
257	394	4.3046	1	2	4	6	8
258	1,023	6.6970	2	3	5	8	13
259	4,793	2.9994	1	1	2	4	6
260	2,078	10.3725	3	5	8	13	21
261	3,592	4.1779	1	2	3	5	8
262	2,423	2.5815	1	1	2	3	5
263	518	5.6602	1	2	3	7	13
264	22,461	8.2590	1	3	6	11	17
265	1,714	3.3495	1	1	2	4	7
280	81,514	6.5098	2	3	5	8	12
281	41,879	4.0679	1	2	3	5	7
282	34,890	2.7555	1	1	2	4	5
283	14,231	4.9678	1	1	3	6	11
284	2,450	2.6686	1	1	1	3	6
285	1,428	1.7983	1	1	1	2	3
286	32,329	6.5479	2	3	5	8	13
287	127,613	3.0171	1	1	2	4	6
288	2,898	10.8037	4	6	9	13	19
289	979	7.2921	3	4	6	9	12
290	240	5.5792	1	3	5	7	10
291	232,185	6.1498	2	3	5	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
292	192,392	4.4947	2	3	4	6	8
293	118,010	3.3080	1	2	3	4	6
294	1,546	5.3668	2	3	5	7	9
295	874	4.0378	1	2	4	5	7
296	2,059	2.7071	1	1	1	3	6
297	629	1.7266	1	1	1	2	3
298	372	1.2097	1	1	1	1	1
299	26,735	6.0663	2	3	5	7	11
300	42,906	4.7095	1	3	4	6	8
301	28,789	3.4713	1	2	3	5	6
302	10,132	3.9515	1	2	3	5	7
303	50,124	2.3738	1	1	2	3	4
304	3,969	4.5382	1	2	4	6	8
305	32,236	2.6866	1	1	2	3	5
306	3,773	5.8049	2	3	4	7	11
307	5,337	3.1731	1	2	3	4	6
308	71,058	5.0115	2	2	4	6	9
309	93,276	3.6117	1	2	3	5	7
310	127,913	2.5033	1	1	2	3	4
311	15,715	2.2386	1	1	2	3	4
312	165,015	2.9422	1	1	2	4	5
313	169,337	2.0617	1	1	2	2	4
314	66,894	6.7151	2	3	5	8	13
315	25,869	4.0866	1	2	3	5	8
316	10,674	2.5722	1	1	2	3	5
326	11,940	16.0999	5	8	13	20	30
327	9,818	8.5639	2	5	7	11	16
328	8,538	3.7853	1	2	3	5	8
329	50,242	15.1759	6	8	13	19	27
330	56,158	8.8715	4	5	7	11	15
331	24,253	5.3159	3	4	5	6	8
332	1,825	13.8553	6	8	11	17	25
333	5,068	7.9820	4	5	7	10	13
334	3,027	4.9045	2	3	5	6	8
335	8,404	13.3221	5	8	12	17	23
336	12,225	8.4806	3	5	7	11	15
337	7,648	5.0911	1	3	4	7	9
338	1,571	9.6295	4	5	8	12	17
339	2,700	6.4174	3	4	6	8	11
340	3,036	3.7286	1	2	3	5	6
341	1,065	6.4939	2	3	5	9	13
342	2,745	3.6947	1	2	3	5	7
343	6,461	2.0108	1	1	2	2	4
344	1,132	10.8843	4	6	9	13	21
345	2,834	6.7759	3	4	6	8	11
346	2,591	4.6299	2	3	4	6	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
347	1,798	8.6029	2	4	6	11	17
348	3,935	5.1624	1	2	4	7	10
349	4,039	2.9153	1	1	2	4	6
350	2,080	7.5846	2	3	6	10	15
351	4,131	4.3053	1	2	4	6	8
352	6,456	2.3748	1	1	2	3	4
353	3,824	8.3227	2	4	7	11	16
354	8,960	4.8608	1	3	4	6	9
355	12,947	2.7752	1	1	2	4	5
356	8,909	12.3348	3	6	9	15	24
357	6,591	7.0678	2	4	6	9	13
358	2,045	4.0088	1	2	3	5	8
368	4,134	6.3464	2	3	5	8	12
369	4,797	4.3688	2	2	4	5	8
370	1,777	3.0833	1	2	3	4	5
371	30,894	8.3267	3	4	6	10	16
372	26,332	6.3285	2	4	5	8	11
373	11,202	4.5867	2	3	4	6	8
374	9,912	8.1968	2	4	6	10	16
375	15,328	5.5969	2	3	4	7	10
376	2,537	3.5861	1	2	3	4	6
377	68,239	6.0023	2	3	5	7	11
378	118,605	4.0662	2	2	3	5	7
379	50,778	3.0378	1	2	3	4	5
380	3,797	7.0608	2	3	5	9	13
381	5,326	4.6707	2	3	4	6	8
382	2,708	3.4830	1	2	3	4	6
383	1,656	5.0290	2	3	4	6	9
384	6,876	3.5609	1	2	3	4	6
385	3,198	7.6826	2	4	6	9	15
386	8,050	5.1593	2	3	4	6	9
387	4,132	3.9131	1	2	3	5	7
388	26,490	6.7018	2	3	5	8	13
389	47,015	4.6775	2	3	4	6	8
390	39,806	3.3390	1	2	3	4	6
391	61,486	4.9306	1	2	4	6	9
392	232,434	3.3799	1	2	3	4	6
393	27,251	6.6114	2	3	5	8	13
394	43,392	4.5431	1	2	4	6	8
395	20,065	3.0842	1	2	3	4	6
405	4,575	15.7388	5	8	12	20	31
406	4,893	8.1721	2	5	7	10	15
407	1,927	5.1520	1	3	5	7	8
408	1,640	13.2659	5	7	11	17	24
409	1,299	8.6343	3	5	7	11	15
410	475	5.8400	2	4	5	7	10

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
411	840	11.7000	5	7	10	14	21
412	780	8.0923	3	5	7	10	13
413	524	5.4027	2	3	5	7	9
414	5,253	11.1961	4	6	9	14	20
415	5,229	7.0692	3	4	6	9	12
416	3,992	4.3790	2	3	4	5	7
417	20,292	7.7720	3	4	6	10	14
418	24,952	5.1565	2	3	4	7	9
419	28,245	3.0297	1	1	2	4	6
420	774	13.0530	3	6	10	17	26
421	846	6.5910	1	3	5	9	13
422	234	4.1068	1	2	3	5	8
423	1,617	14.1472	4	7	11	18	28
424	672	8.6577	3	4	7	11	16
425	86	5.6860	2	3	4	7	10
432	13,529	6.4975	2	3	5	8	13
433	6,969	4.3401	1	2	4	5	8
434	398	3.1734	1	2	3	4	6
435	13,761	7.2943	2	3	6	9	14
436	11,039	5.3120	2	3	4	7	10
437	2,182	3.6856	1	2	3	5	7
438	19,674	7.0637	2	3	5	9	14
439	23,206	4.8099	2	3	4	6	9
440	20,560	3.4957	1	2	3	4	6
441	18,105	6.8437	2	3	5	8	14
442	14,938	4.5243	1	2	4	6	8
443	4,688	3.3057	1	2	3	4	6
444	14,810	6.1409	2	3	5	8	11
445	16,827	4.3909	1	2	4	6	8
446	12,789	3.0593	1	2	3	4	6
453	1,255	13.0876	5	6	10	16	25
454	2,962	6.6357	3	4	5	8	12
455	2,482	3.7526	1	2	3	5	6
456	1,241	13.1475	5	7	10	16	24
457	3,086	6.8568	3	4	6	8	12
458	1,565	4.0505	2	3	4	5	7
459	4,695	8.6505	3	5	7	10	16
460	60,945	3.8373	2	2	3	5	6
461	947	7.2893	3	4	6	8	13
462	11,067	4.0499	3	3	3	4	6
463	6,113	14.7572	4	7	11	18	29
464	7,907	8.5108	3	4	7	10	16
465	2,708	5.2688	2	3	4	6	9
466	4,780	8.5090	3	4	7	10	15
467	19,097	4.8438	3	3	4	6	8
468	15,812	3.5808	2	3	3	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
469	35,893	7.4293	3	4	6	9	13
470	404,338	3.6454	2	3	3	4	5
471	2,991	9.2207	2	4	7	13	18
472	8,421	3.6774	1	1	2	5	8
473	25,112	1.8500	1	1	1	2	3
474	3,277	11.8758	4	6	9	15	22
475	3,428	7.3629	2	4	6	9	14
476	1,134	4.0908	1	2	3	5	8
477	3,256	10.7457	4	6	9	13	19
478	8,249	6.6555	1	3	6	9	12
479	5,867	3.3936	1	1	2	5	7
480	31,193	8.4968	4	5	7	10	15
481	74,874	5.4504	3	4	5	6	8
482	33,902	4.4797	3	3	4	5	7
483	10,324	3.7260	2	2	3	4	7
484	18,014	2.1959	1	1	2	3	3
485	1,261	10.5147	4	6	8	13	19
486	2,153	7.0060	3	4	6	8	12
487	1,058	5.0888	2	3	4	6	8
488	3,248	4.6918	2	3	3	5	8
489	4,902	2.8499	1	2	3	3	5
490	22,903	4.2505	1	2	3	5	9
491	45,224	2.0655	1	1	1	3	4
492	6,706	8.1353	3	4	7	10	15
493	18,839	4.8463	2	3	4	6	8
494	25,249	3.1465	1	2	3	4	5
495	1,890	9.9476	3	5	8	12	19
496	4,609	5.1833	1	2	4	7	10
497	5,130	2.5558	1	1	2	3	5
498	1,481	7.2552	2	3	6	9	14
499	876	2.9920	1	1	2	3	5
500	2,283	10.1783	3	5	8	13	20
501	4,635	5.7282	2	3	5	7	11
502	5,741	2.8021	1	1	2	3	5
503	1,174	8.4361	3	4	7	11	16
504	2,548	5.9863	2	3	5	8	11
505	2,256	3.1272	1	1	3	4	6
506	717	3.7992	1	1	3	5	8
507	940	4.5160	1	2	3	5	9
508	1,782	2.0561	1	1	2	3	3
509	349	3.4699	1	1	2	4	7
510	1,275	6.1569	2	3	5	8	11
511	4,095	3.8112	1	2	3	5	7
512	8,255	2.1474	1	1	2	3	4
513	1,248	4.8205	1	2	4	6	9
514	921	2.6406	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
515	4,912	9.3950	3	5	8	11	17
516	11,267	5.7698	2	3	5	7	10
517	11,169	3.3660	1	1	3	5	7
533	1,004	6.2490	2	3	5	8	12
534	3,277	3.8145	1	2	3	5	7
535	9,037	5.5860	2	3	4	7	10
536	31,028	3.6752	1	3	3	4	6
537	944	4.0911	2	3	3	5	7
538	708	3.0494	1	2	3	4	5
539	3,683	9.2359	3	5	7	11	16
540	3,800	6.6839	2	4	5	8	11
541	1,124	4.8488	1	2	4	6	8
542	7,101	7.9687	3	4	6	10	15
543	15,205	5.5178	2	3	4	7	10
544	6,624	4.0503	2	3	3	5	7
545	4,543	8.6212	2	4	6	11	18
546	5,210	5.0029	2	3	4	6	9
547	3,348	3.5358	1	2	3	4	6
548	728	8.6181	3	4	7	10	16
549	1,066	5.7645	2	3	5	7	10
550	556	4.0108	1	2	3	5	7
551	14,610	6.4630	2	3	5	8	12
552	73,510	3.8977	1	2	3	5	7
553	4,040	5.3376	2	3	4	6	9
554	15,436	3.4756	1	2	3	4	6
555	3,445	4.7660	1	2	4	6	9
556	16,663	3.1124	1	2	3	4	6
557	6,796	6.2217	2	3	5	7	11
558	14,146	4.1105	2	3	4	5	7
559	2,281	6.9833	2	3	5	9	14
560	4,922	4.5211	1	2	4	6	8
561	5,314	2.6314	1	1	2	3	5
562	7,806	5.6471	2	3	4	7	10
563	30,486	3.4819	1	2	3	4	6
564	2,149	6.4044	2	3	5	8	12
565	3,699	4.5250	1	3	4	6	8
566	1,759	3.4179	1	2	3	4	6
573	5,749	12.2113	4	6	9	14	23
574	9,057	8.3095	3	4	7	10	15
575	3,721	5.1774	2	3	4	7	9
576	780	12.9000	3	5	9	17	26
577	2,280	5.7974	1	2	4	7	12
578	2,530	3.2573	1	1	2	4	6
579	4,595	10.2448	3	5	8	13	19
580	10,731	5.0932	1	2	4	7	10
581	10,753	2.3869	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
582	4,901	2.6566	1	1	2	3	5
583	7,581	1.7392	1	1	1	2	3
584	862	4.9617	1	2	4	7	10
585	1,462	2.1382	1	1	1	3	4
592	4,964	7.9746	2	4	6	9	14
593	10,203	5.7727	2	3	5	7	10
594	1,483	4.6703	1	2	4	6	8
595	1,674	7.2832	2	4	6	9	14
596	4,415	4.4208	1	2	4	5	8
597	695	7.5007	2	3	6	9	13
598	1,384	5.2854	1	2	4	7	10
599	185	3.2757	1	1	3	4	5
600	1,034	4.9207	2	3	4	6	9
601	778	3.6157	1	2	3	5	6
602	33,771	6.4584	2	3	5	8	12
603	127,084	4.4100	2	3	4	5	8
604	3,668	4.9738	1	2	4	6	9
605	19,162	3.2558	1	2	3	4	6
606	2,247	5.6805	1	3	4	7	11
607	6,374	3.4934	1	2	3	4	6
614	1,706	6.5774	2	3	5	8	13
615	1,449	2.9717	1	2	3	4	5
616	1,678	15.5936	6	8	13	19	28
617	6,516	7.8996	3	4	7	10	14
618	148	5.1419	2	3	4	6	9
619	1,009	7.3310	1	2	4	8	15
620	2,993	3.1617	1	2	2	4	6
621	11,368	1.8438	1	1	2	2	3
622	1,232	12.1640	4	6	9	14	22
623	2,455	7.5825	3	4	6	9	13
624	236	4.8347	2	3	4	6	8
625	1,309	7.0963	1	2	5	9	15
626	2,852	2.8159	1	1	2	3	6
627	12,254	1.4115	1	1	1	1	2
628	3,718	10.5662	2	4	8	13	20
629	4,451	7.9232	3	4	7	10	14
630	446	4.4619	1	2	3	6	8
637	26,230	5.4669	2	3	4	7	10
638	46,738	3.9819	1	2	3	5	7
639	24,880	2.8062	1	1	2	3	5
640	79,621	4.7818	1	2	3	6	9
641	164,528	3.5115	1	2	3	4	6
642	1,603	4.7436	1	2	3	6	9
643	7,683	7.2309	2	4	6	9	13
644	11,845	5.0712	2	3	4	6	9
645	6,422	3.5668	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
652	10,211	7.5052	4	5	6	8	13
653	2,013	15.8987	6	8	13	20	29
654	3,404	9.0858	5	6	8	11	15
655	1,275	5.6549	2	4	6	7	9
656	4,888	9.4728	3	5	7	11	18
657	7,350	5.3278	2	3	5	6	9
658	6,807	3.3676	1	2	3	4	5
659	5,503	10.1098	3	4	8	13	20
660	7,095	5.6238	2	3	4	7	11
661	3,862	2.8933	1	2	2	4	5
662	1,015	10.2749	2	4	8	12	21
663	1,820	4.8462	1	2	3	6	10
664	3,282	1.8525	1	1	1	2	3
665	884	10.5271	3	5	9	13	20
666	1,878	5.9361	1	2	4	8	12
667	2,595	2.3680	1	1	2	3	4
668	5,500	7.7095	2	3	6	10	15
669	12,259	4.0007	1	2	3	5	8
670	8,764	2.2913	1	1	2	3	5
671	799	5.5920	1	2	4	7	11
672	635	2.2000	1	1	2	3	4
673	12,494	9.5253	1	3	7	12	20
674	8,802	6.5558	1	2	5	9	14
675	3,252	2.1125	1	1	1	2	5
682	102,211	6.7567	2	3	5	8	13
683	114,329	4.9315	2	3	4	6	9
684	26,729	3.3482	1	2	3	4	6
685	2,513	3.3979	1	1	2	4	7
686	1,940	7.0340	2	3	5	9	14
687	2,618	4.6902	1	2	4	6	8
688	706	2.8031	1	1	2	3	5
689	89,105	5.4897	2	3	4	7	10
690	185,262	3.9692	2	2	3	5	7
691	999	4.3053	1	2	3	5	9
692	380	2.2421	1	1	2	3	4
693	4,313	4.3438	1	2	3	6	8
694	15,245	2.3793	1	1	2	3	4
695	1,361	5.3475	1	3	4	7	10
696	9,992	3.1414	1	2	3	4	6
697	509	3.1100	1	1	2	4	6
698	32,063	6.3485	2	3	5	8	12
699	23,186	4.4403	1	2	4	6	8
700	8,115	3.2223	1	2	3	4	6
707	5,392	4.2381	1	2	3	5	8
708	16,899	1.8647	1	1	2	2	3
709	817	5.6793	1	1	3	7	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
710	1,504	1.6642	1	1	1	2	3
711	740	7.2986	1	3	5	9	15
712	424	2.6604	1	1	2	3	5
713	9,760	4.0614	1	2	3	5	9
714	22,626	1.8214	1	1	2	2	3
715	505	6.0554	1	2	4	8	13
716	685	1.3518	1	1	1	1	2
717	734	6.4074	1	3	5	8	13
718	446	2.6121	1	1	2	3	5
722	907	6.8655	2	3	5	8	13
723	1,505	4.8213	1	2	4	6	9
724	276	2.6957	1	1	2	3	5
725	1,368	4.8450	2	2	4	6	9
726	3,010	3.2664	1	2	3	4	6
727	2,292	6.0105	2	3	5	7	11
728	5,331	3.9081	1	2	3	5	7
729	838	4.6802	1	2	4	6	9
730	276	2.8442	1	1	2	3	5
734	1,520	6.9493	2	3	5	8	14
735	1,138	2.6951	1	1	2	4	5
736	1,046	13.6434	5	7	11	17	25
737	3,134	6.4467	3	4	6	8	11
738	712	3.5941	2	2	3	4	5
739	1,106	9.4313	3	4	7	11	19
740	4,261	4.5226	2	3	4	5	8
741	5,393	2.5524	1	1	2	3	4
742	10,807	4.1279	1	2	3	5	8
743	27,700	2.0692	1	1	2	3	3
744	1,625	5.5680	1	2	4	7	11
745	1,265	2.4403	1	1	2	3	5
746	2,621	4.1801	1	2	3	5	8
747	7,265	1.7794	1	1	1	2	3
748	17,103	1.6853	1	1	1	2	3
749	1,052	8.4753	2	4	7	11	16
750	362	2.7901	1	1	2	3	5
754	1,471	8.2998	2	4	6	11	16
755	2,959	5.0057	1	2	4	6	9
756	440	3.0750	1	1	2	4	6
757	1,772	7.5056	3	4	6	9	14
758	1,770	5.4650	2	3	5	7	10
759	978	4.0112	2	2	3	5	7
760	2,269	3.7532	1	2	3	5	7
761	1,138	2.2417	1	1	2	3	4
765	3,417	4.8674	2	3	4	5	7
766	2,757	3.0812	2	2	3	4	4
767	169	2.6864	2	2	2	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
768	8	6.7500	1	2	5	6	13
769	122	5.7459	1	2	4	7	13
770	177	2.0904	1	1	1	2	4
774	1,667	3.2190	2	2	2	3	4
775	5,860	2.3258	1	2	2	3	3
776	588	3.3248	1	2	2	4	6
777	198	2.0505	1	1	2	3	4
778	444	3.2050	1	1	2	3	6
779	121	2.1405	1	1	1	2	4
780	42	1.6190	1	1	1	1	2
781	3,387	3.8432	1	1	3	4	7
782	188	2.6117	1	1	2	3	5
793	3	3.6667	1	1	3	7	7
794	1	1.0000	1	1	1	1	1
799	582	13.2405	4	7	11	17	25
800	641	7.2246	2	4	6	9	14
801	357	3.9076	1	2	3	5	7
802	1,095	11.7826	3	5	8	13	21
803	1,004	6.0936	2	3	5	7	11
804	764	2.9686	1	1	2	4	6
808	9,279	8.0600	2	4	6	10	15
809	13,025	4.9646	2	3	4	6	9
810	2,170	3.7392	1	2	3	5	7
811	37,741	5.1436	1	2	4	6	10
812	91,512	3.5555	1	2	3	4	7
813	11,471	4.9750	1	2	4	6	10
814	2,052	6.6774	2	3	5	8	12
815	3,337	4.4489	1	2	4	5	8
816	1,532	3.2428	1	2	3	4	6
820	1,396	17.0659	5	8	13	22	33
821	1,934	7.0817	1	3	5	9	15
822	1,738	3.0984	1	1	2	4	6
823	2,425	14.9126	5	7	12	18	28
824	2,581	8.1395	2	4	7	11	16
825	1,442	3.9286	1	1	3	5	8
826	680	14.2985	5	7	11	18	27
827	1,420	6.6838	2	3	5	8	13
828	696	3.7586	1	2	3	5	7
829	1,398	9.3369	2	3	7	11	20
830	385	3.1247	1	1	2	4	6
834	4,288	15.1749	2	4	9	23	35
835	2,465	9.3513	2	3	5	10	25
836	1,201	4.4388	1	2	3	5	8
837	1,390	22.5914	5	8	22	31	42
838	1,431	12.2697	3	4	6	20	30
839	1,284	5.6830	2	4	5	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
840	9,929	10.0469	3	4	8	13	20
841	8,550	6.3908	2	3	5	8	12
842	3,644	4.1715	1	2	3	5	8
843	1,876	7.7953	2	4	6	10	14
844	2,566	5.4189	2	3	4	7	10
845	667	3.7676	1	2	3	5	7
846	3,055	7.8206	2	3	5	9	17
847	21,591	3.3495	1	2	3	4	6
848	1,107	2.9883	1	1	3	4	5
849	1,163	6.0404	2	3	5	6	11
853	42,325	15.3906	5	8	12	19	28
854	5,584	9.1653	3	5	8	11	16
855	337	5.3976	1	2	4	7	10
856	6,574	14.8006	4	7	11	18	28
857	9,165	7.5920	3	4	6	9	14
858	2,325	5.0533	2	3	4	6	9
862	10,485	7.6788	2	4	6	9	15
863	20,692	4.7970	2	3	4	6	8
864	18,172	3.7732	1	2	3	5	7
865	3,069	6.0336	2	3	4	7	12
866	6,641	3.3212	1	2	3	4	6
867	5,759	8.9976	2	4	7	11	18
868	2,409	5.1582	2	3	4	6	9
869	779	3.6393	1	2	3	4	6
870	25,752	15.1737	6	9	13	18	26
871	280,970	7.0555	2	3	6	9	13
872	75,906	5.1518	2	3	4	6	9
876	656	12.6799	2	4	8	14	29
880	8,144	3.0149	1	1	2	4	6
881	4,536	4.2377	1	2	3	5	8
882	1,797	4.2966	1	2	3	5	8
883	863	7.7034	1	3	5	8	15
884	18,110	5.3720	2	3	4	6	9
885	88,160	7.3601	2	3	6	9	13
886	525	6.1657	1	2	4	6	12
887	466	4.0494	1	2	3	5	7
894	4,520	2.9412	1	1	2	3	4
895	6,273	10.9396	3	4	6	8	9
896	8,621	6.1897	2	3	4	7	11
897	35,167	3.9315	1	2	3	4	6
901	1,074	13.7719	3	5	9	17	29
902	1,753	7.1843	2	3	5	8	14
903	1,027	4.4450	1	2	3	5	8
904	1,895	11.1135	2	4	7	13	23
905	763	4.5242	1	2	4	6	9
906	707	3.0905	1	1	2	3	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
907	9,288	11.0101	3	5	8	14	22
908	8,383	6.1103	2	3	5	8	12
909	4,760	3.3786	1	1	3	4	7
913	1,159	5.3572	1	2	4	6	10
914	5,171	3.1251	1	1	3	4	6
915	1,808	4.6858	1	2	3	6	9
916	5,255	2.0278	1	1	1	2	4
917	22,772	4.9226	1	2	4	6	10
918	33,100	2.6100	1	1	2	3	5
919	12,011	6.1429	2	3	4	7	12
920	14,002	4.1465	1	2	3	5	8
921	7,314	2.8138	1	1	2	3	5
922	1,467	5.0266	1	2	4	6	10
923	2,780	3.1299	1	1	2	4	5
927	188	28.2128	8	13	23	39	55
928	948	14.8597	3	7	12	20	29
929	366	7.6721	1	3	6	10	15
933	138	5.2319	1	1	1	5	12
934	608	5.8257	1	2	4	7	11
935	2,111	5.2321	1	2	3	6	10
939	816	9.8750	2	4	7	13	20
940	1,539	5.1313	1	2	3	7	11
941	1,455	2.5904	1	1	2	3	5
945	5,971	10.1921	4	6	8	11	15
946	2,809	7.4938	3	5	6	7	8
947	15,418	4.8159	1	2	4	6	9
948	52,323	3.3628	1	2	3	4	6
949	640	4.2969	1	1	2	4	7
950	276	2.7572	1	1	2	3	4
951	1,028	4.5360	1	1	2	3	6
955	443	12.6456	3	5	9	17	24
956	4,421	8.4180	4	5	7	10	15
957	1,516	14.0468	3	7	11	18	27
958	1,134	9.5273	3	5	8	12	16
959	200	5.5800	2	3	5	7	10
963	2,001	8.4983	1	3	7	11	18
964	2,672	5.4963	2	3	5	7	10
965	913	3.7558	1	2	3	5	7
969	638	17.0611	4	7	13	22	35
970	95	8.4526	1	3	7	12	17
974	6,029	9.3641	2	4	7	12	18
975	3,693	6.4075	2	3	5	8	12
976	1,529	4.4173	1	2	3	5	7
977	3,547	4.8765	1	2	4	6	9
981	28,575	13.8055	4	7	11	17	26
982	16,651	8.2634	2	4	7	11	15
983	4,894	4.2284	1	2	3	6	9
984	747	12.6051	4	7	11	16	22
985	814	8.4017	2	4	7	12	16
986	447	4.0559	1	1	2	6	9
987	9,573	11.8354	3	6	10	15	22
988	9,352	7.0079	2	3	6	9	14
989	3,950	3.5337	1	1	2	5	7
	10,957,307						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGHTS OF STAY; FY 2009 MedPAR UPDATE – DECEMBER 2009 GROUPER V28.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	907	41.8412	12	19	33	53	82
2	333	22.7628	9	12	17	29	42
3	21,956	36.6115	15	21	30	44	63
4	21,395	27.1269	11	16	22	32	46
5	889	19.9944	6	9	14	25	43
6	408	9.2255	5	6	8	11	14
7	469	18.7058	8	11	15	23	31
8	509	11.7741	6	7	9	13	21
10	137	9.7007	5	7	8	11	13
11	1,466	15.5989	6	8	12	19	29
12	1,963	10.0942	4	6	8	13	17
13	1,008	6.7401	3	4	6	8	11
14	446	27.7489	7	19	25	34	50
15	1,372	19.2449	10	15	18	22	28
20	1,081	17.2026	6	10	16	23	29
21	469	13.9382	7	10	14	17	22
22	146	8.3767	2	4	8	12	14
23	4,406	11.7690	2	5	9	16	23
24	1,708	8.0878	1	3	7	11	16
25	11,582	11.5431	3	6	9	15	22
26	11,469	7.3239	2	4	6	9	14
27	12,591	3.8861	1	2	3	5	7
28	1,851	13.1059	4	6	11	16	25
29	3,505	6.5629	1	3	5	9	13
30	3,432	3.2797	1	1	3	4	7
31	1,169	12.2104	2	5	9	16	25
32	2,808	5.3711	1	2	4	7	12
33	3,351	2.6640	1	1	2	3	5
34	819	7.0195	1	2	6	10	15
35	2,336	3.2140	1	1	2	4	8
36	5,732	1.5223	1	1	1	1	3
37	4,944	8.3833	1	3	7	11	18
38	14,449	3.5553	1	1	2	5	8
39	43,823	1.6743	1	1	1	2	3
40	4,817	12.1704	3	6	9	15	23
41	7,552	6.6622	1	3	6	8	13
42	3,808	3.2261	1	1	2	4	7
52	1,250	6.6328	2	3	5	7	11
53	487	3.5832	1	2	3	5	6
54	7,208	6.2757	2	3	5	8	12
55	13,028	4.6122	1	2	3	6	9
56	9,289	7.1527	2	3	5	9	14
57	43,231	4.8535	2	3	4	6	8
58	893	7.2878	2	3	5	9	14
59	3,250	4.9237	2	3	4	6	8
60	3,515	3.7713	1	2	3	5	6
61	2,266	8.3530	2	4	7	11	16
62	3,739	5.6448	2	3	5	7	10
63	1,309	3.9152	2	2	3	5	7
64	60,945	6.9291	2	3	5	9	14
65	112,612	4.8351	2	3	4	6	9
66	66,535	3.2734	1	2	3	4	6
67	1,387	5.4737	2	3	4	7	10
68	10,376	3.3077	1	2	3	4	6
69	92,535	2.7913	1	2	2	3	5
70	9,646	7.3534	2	3	6	9	14
71	13,708	5.1401	2	3	4	6	9
72	4,838	3.1174	1	2	2	4	6
73	8,926	5.6255	2	3	4	7	11
74	31,568	4.0866	1	2	3	5	7
75	1,348	6.9733	2	4	5	8	13
76	661	3.9259	1	2	3	5	7
77	1,519	6.4352	2	3	5	8	12
78	2,122	4.3907	1	2	4	5	8
79	774	3.0749	1	2	3	4	5
80	1,625	4.9145	1	2	4	6	10
81	5,867	3.4137	1	2	3	4	6
82	2,372	6.0544	1	1	4	8	13
83	2,596	4.6541	1	2	4	6	9
84	2,542	2.7825	1	1	2	4	5
85	7,305	7.2197	2	3	6	9	14
86	14,311	4.6416	1	2	4	6	8
87	13,012	2.9085	1	1	2	4	5
88	870	5.5345	2	3	4	7	11
89	3,155	3.6960	1	2	3	5	7
90	2,481	2.3136	1	1	2	3	4
91	8,739	6.2049	1	3	4	7	13
92	19,751	4.2052	1	2	3	5	8
93	13,215	2.8862	1	1	2	4	5
94	1,426	11.8296	3	6	10	15	21
95	1,186	8.3727	3	5	7	11	15
96	540	5.6667	1	4	5	7	10
97	1,187	11.6352	4	6	9	15	22
98	1,065	7.8892	3	4	7	10	14
99	423	5.1915	2	3	4	7	10
100	19,259	5.9589	2	3	4	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
101	56,054	3.4365	1	2	3	4	6
102	1,285	4.2716	1	2	3	5	9
103	12,526	3.0242	1	1	2	4	6
113	639	5.5994	1	2	4	7	11
114	431	2.5986	1	1	2	3	5
115	850	4.6082	1	2	4	5	7
116	455	4.4813	1	1	2	5	7
117	549	1.9872	1	1	1	1	2
121	744	5.1022	2	3	4	6	8
122	524	3.9790	1	2	3	5	7
123	2,672	2.7182	1	1	2	3	5
124	739	5.2612	1	2	4	6	11
125	4,274	3.3538	1	2	3	4	6
129	1,508	5.2454	1	2	4	7	11
130	943	2.8908	1	1	2	4	6
131	1,132	5.5998	1	2	4	7	11
132	748	2.7126	1	1	2	3	5
133	2,242	5.3965	1	2	4	7	11
134	2,627	2.0837	1	1	1	2	4
135	466	6.3112	1	2	5	9	13
136	351	2.2422	1	1	1	3	5
137	891	4.9989	1	2	4	6	10
138	747	2.4873	1	1	2	3	5
139	1,363	1.7601	1	1	1	2	3
146	734	9.0327	2	4	7	11	19
147	1,362	5.7379	1	2	4	7	11
148	552	3.3442	1	1	2	4	6
149	33,609	2.6159	1	1	2	3	5
150	1,162	4.9699	1	2	4	6	10
151	6,166	2.8774	1	1	2	4	5
152	2,298	4.2963	1	2	3	5	8
153	11,465	3.0804	1	2	3	4	5
154	2,458	5.7754	1	3	4	7	12
155	6,154	4.2238	1	2	3	5	8
156	3,515	2.8942	1	1	2	4	5
157	1,374	6.6798	2	3	5	8	14
158	3,709	4.3308	1	2	3	5	8
159	1,459	2.7347	1	1	2	3	5
163	13,439	14.0385	5	8	12	18	25
164	18,804	7.3844	3	4	6	9	13
165	10,518	4.3993	2	3	4	6	7
166	23,100	11.9825	4	6	10	15	22
167	19,782	7.3702	2	4	6	9	14
168	4,388	4.2985	1	2	3	6	8
175	14,080	6.8241	3	4	6	8	12
176	36,658	4.9333	2	3	5	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
177	68,128	8.5605	3	5	7	11	16
178	71,807	6.7933	3	4	6	8	12
179	16,039	4.9675	2	3	4	6	9
180	20,637	7.4786	2	4	6	10	14
181	26,198	5.4244	1	3	4	7	10
182	2,840	3.6532	1	2	3	5	7
183	2,664	6.4842	2	3	5	8	12
184	5,184	4.3119	2	3	4	5	8
185	2,187	3.0393	1	2	3	4	5
186	10,686	6.7318	2	3	5	9	13
187	10,944	4.9400	1	2	4	6	9
188	3,293	3.5299	1	2	3	4	7
189	94,058	5.5455	2	3	4	7	10
190	136,856	5.5075	2	3	5	7	10
191	150,358	4.6481	2	3	4	6	8
192	134,412	3.6580	1	2	3	5	6
193	103,907	6.4847	2	4	5	8	12
194	207,054	4.9783	2	3	4	6	9
195	87,008	3.6926	1	2	3	5	6
196	6,959	6.9585	2	4	6	9	13
197	6,790	5.1077	2	3	4	6	9
198	3,047	3.7670	1	2	3	5	7
199	3,790	8.0317	2	4	6	10	15
200	8,675	4.7641	1	2	4	6	9
201	2,745	3.5457	1	2	3	5	7
202	38,888	4.1342	1	2	3	5	7
203	28,980	3.1588	1	2	3	4	6
204	23,390	2.7325	1	1	2	3	5
205	6,677	5.3037	1	2	4	7	10
206	19,984	3.2516	1	2	3	4	6
207	36,288	14.7898	6	9	13	18	25
208	74,965	7.0337	1	3	6	9	14
215	177	12.6215	1	3	8	14	28
216	9,532	17.0712	8	11	15	21	29
217	6,915	10.9643	6	7	10	13	18
218	1,222	7.9869	5	6	7	9	12
219	12,766	13.1024	5	7	11	16	24
220	16,882	7.9647	4	6	7	9	13
221	4,475	5.9678	4	5	6	7	9
222	2,754	11.8500	4	6	10	15	22
223	3,843	6.1897	1	2	5	8	12
224	2,738	9.7064	3	5	8	12	18
225	4,489	5.2947	2	3	5	7	10
226	7,266	7.7703	1	2	6	11	16
227	30,144	3.1103	1	1	1	4	7
228	2,305	14.2430	6	8	12	18	25

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
229	2,849	8.3155	4	5	7	10	14
230	806	5.5186	2	4	5	7	9
231	1,351	12.9067	6	8	11	16	22
232	1,220	9.4139	5	7	9	11	14
233	15,293	13.7411	7	9	12	16	23
234	27,437	8.8794	5	6	8	11	13
235	9,468	10.8477	5	6	9	13	19
236	25,502	6.5346	4	5	6	8	10
237	22,101	10.1669	2	4	8	13	20
238	40,058	4.1976	1	1	3	6	9
239	10,869	14.3506	5	7	11	18	27
240	10,791	9.6381	3	5	8	12	18
241	1,552	5.9852	2	3	5	8	11
242	17,882	8.0936	2	4	6	10	15
243	41,262	4.9405	1	2	4	6	9
244	44,828	2.8119	1	1	2	4	6
245	3,970	3.8071	1	1	2	5	8
246	30,909	5.0086	1	2	4	6	10
247	143,976	2.2759	1	1	2	3	4
248	14,361	6.0490	1	3	5	8	12
249	46,400	2.7896	1	1	2	3	5
250	7,652	6.9611	2	3	5	9	14
251	36,441	2.9462	1	1	2	4	6
252	40,567	7.8947	1	3	6	10	17
253	44,596	6.0032	1	2	5	8	12
254	38,370	2.6631	1	1	2	3	6
255	2,483	9.2114	2	4	7	12	17
256	3,196	7.0219	2	4	6	9	13
257	394	4.3046	1	2	4	6	8
258	763	6.9685	2	3	5	9	13
259	5,053	3.1486	1	1	2	4	6
260	1,770	10.7571	2	5	8	14	22
261	3,900	4.4926	1	2	3	6	9
262	2,423	2.5815	1	1	2	3	5
263	518	5.6602	1	2	3	7	13
264	22,461	8.2590	1	3	6	11	17
265	1,714	3.3495	1	1	2	4	7
280	70,000	6.6250	2	3	5	8	12
281	53,393	4.4435	1	2	4	6	8
282	34,890	2.7555	1	1	2	4	5
283	12,651	5.1395	1	1	3	7	12
284	4,030	3.0310	1	1	2	4	7
285	1,428	1.7983	1	1	1	2	3
286	25,188	6.4764	2	3	5	8	13
287	134,754	3.2176	1	1	2	4	6
288	2,679	10.8634	4	6	9	13	19

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
289	1,198	7.8005	3	5	7	10	13
290	240	5.5792	1	3	5	7	10
291	176,332	6.1577	2	3	5	8	12
292	248,245	4.8614	2	3	4	6	9
293	118,010	3.3080	1	2	3	4	6
294	1,546	5.3668	2	3	5	7	9
295	874	4.0378	1	2	4	5	7
296	1,921	2.7673	1	1	1	3	6
297	767	1.7523	1	1	1	2	3
298	372	1.2097	1	1	1	1	1
299	21,223	6.0532	2	3	5	7	11
300	48,418	4.8697	2	3	4	6	8
301	28,789	3.4713	1	2	3	5	6
302	7,760	3.9586	1	2	3	5	7
303	52,496	2.4440	1	1	2	3	4
304	2,867	4.5438	1	2	3	6	8
305	33,338	2.7473	1	1	2	3	5
306	3,079	5.9328	2	3	4	7	11
307	6,031	3.4107	1	2	3	4	6
308	56,626	5.1614	2	3	4	6	10
309	107,708	3.7205	1	2	3	5	7
310	127,913	2.5033	1	1	2	3	4
311	15,715	2.2386	1	1	2	3	4
312	165,015	2.9422	1	1	2	4	5
313	169,337	2.0617	1	1	2	2	4
314	61,174	6.8924	2	3	5	9	13
315	31,589	4.2192	1	2	3	5	8
316	10,674	2.5722	1	1	2	3	5
326	11,327	16.2594	5	8	13	20	30
327	10,431	8.8336	2	5	7	11	16
328	8,538	3.7853	1	2	3	5	8
329	46,072	15.4141	6	8	13	19	28
330	60,328	9.1253	4	6	8	11	16
331	24,253	5.3159	3	4	5	6	8
332	1,602	14.2085	6	8	12	18	26
333	5,291	8.1227	4	5	7	10	14
334	3,027	4.9045	2	3	5	6	8
335	7,054	13.7044	5	8	12	17	24
336	13,575	8.7634	3	5	8	11	15
337	7,648	5.0911	1	3	4	7	9
338	1,283	10.0405	4	6	8	13	17
339	2,988	6.5505	3	4	6	8	11
340	3,036	3.7286	1	2	3	5	6
341	907	6.6185	2	3	5	9	13
342	2,903	3.8081	1	2	3	5	7
343	6,461	2.0108	1	1	2	2	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
344	914	11.1838	4	6	9	14	21
345	3,052	6.9797	3	4	6	8	12
346	2,591	4.6299	2	3	4	6	7
347	1,478	8.7794	2	4	6	11	17
348	4,255	5.3598	2	3	4	7	10
349	4,039	2.9153	1	1	2	4	6
350	1,676	7.7739	2	3	6	10	15
351	4,535	4.5275	1	2	4	6	9
352	6,456	2.3748	1	1	2	3	4
353	3,228	8.4365	2	4	7	11	16
354	9,556	5.0383	2	3	4	6	9
355	12,947	2.7752	1	1	2	4	5
356	7,895	12.6730	3	6	10	16	24
357	7,605	7.4191	2	4	6	9	14
358	2,045	4.0088	1	2	3	5	8
368	3,305	6.6865	2	3	5	8	12
369	5,626	4.4604	2	3	4	5	8
370	1,777	3.0833	1	2	3	4	5
371	22,536	8.8666	3	4	7	11	17
372	34,690	6.4592	2	4	5	8	12
373	11,202	4.5867	2	3	4	6	8
374	8,074	8.4488	2	4	7	11	16
375	17,166	5.7567	2	3	4	7	11
376	2,537	3.5861	1	2	3	4	6
377	48,282	6.4252	2	3	5	8	12
378	138,562	4.1977	2	2	4	5	7
379	50,778	3.0378	1	2	3	4	5
380	2,927	7.5364	2	4	6	9	14
381	6,196	4.7816	2	3	4	6	9
382	2,708	3.4830	1	2	3	4	6
383	1,131	5.2856	2	3	4	6	9
384	7,401	3.6259	1	2	3	4	6
385	2,207	8.3715	2	4	6	10	16
386	9,041	5.2677	2	3	4	7	10
387	4,132	3.9131	1	2	3	5	7
388	18,652	7.2489	2	3	6	9	14
389	54,853	4.7808	2	3	4	6	9
390	39,806	3.3390	1	2	3	4	6
391	45,147	5.1526	1	2	4	6	10
392	248,773	3.4414	1	2	3	4	6
393	21,581	6.8656	2	3	5	8	14
394	49,062	4.6703	1	2	4	6	9
395	20,065	3.0842	1	2	3	4	6
405	4,357	15.8947	5	8	12	20	31
406	5,111	8.3620	2	5	7	10	15
407	1,927	5.1520	1	3	5	7	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
408	1,493	13.4662	5	7	11	17	24
409	1,446	8.8983	4	5	8	11	16
410	475	5.8400	2	4	5	7	10
411	782	11.7852	5	7	10	14	21
412	838	8.2625	3	5	7	10	14
413	524	5.4027	2	3	5	7	9
414	4,700	11.3732	4	6	9	14	20
415	5,782	7.3200	3	4	6	9	12
416	3,992	4.3790	2	3	4	5	7
417	17,753	7.8448	3	4	6	10	15
418	27,491	5.3511	2	3	5	7	10
419	28,245	3.0297	1	1	2	4	6
420	712	13.1110	3	6	10	17	27
421	908	6.9868	2	3	5	9	14
422	234	4.1068	1	2	3	5	8
423	1,487	14.3658	4	7	11	18	28
424	802	9.1421	3	5	7	11	17
425	86	5.6860	2	3	4	7	10
432	12,413	6.5409	2	3	5	8	13
433	8,085	4.5713	1	2	4	6	8
434	398	3.1734	1	2	3	4	6
435	12,205	7.3902	2	3	6	9	14
436	12,595	5.4640	2	3	4	7	10
437	2,182	3.6856	1	2	3	5	7
438	14,979	7.4713	2	3	5	9	15
439	27,901	4.9703	2	3	4	6	9
440	20,560	3.4957	1	2	3	4	6
441	14,431	7.1160	2	3	5	9	14
442	18,612	4.7711	2	2	4	6	9
443	4,688	3.3057	1	2	3	4	6
444	12,611	6.2323	2	3	5	8	12
445	19,026	4.5326	1	2	4	6	8
446	12,789	3.0593	1	2	3	4	6
453	1,133	13.4704	5	7	10	17	26
454	3,084	6.7503	3	4	5	8	13
455	2,482	3.7526	1	2	3	5	6
456	1,130	13.4611	5	7	10	17	25
457	3,197	6.9643	3	4	6	8	12
458	1,565	4.0505	2	3	4	5	7
459	3,823	9.0876	4	5	7	11	17
460	61,817	3.8782	2	3	3	5	6
461	638	8.3103	3	4	7	9	15
462	11,376	4.0806	3	3	3	4	6
463	5,302	15.1032	4	7	11	18	30
464	8,718	8.8815	3	4	7	11	17
465	2,708	5.2688	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
466	3,705	8.9744	3	5	7	11	16
467	20,172	4.9536	3	3	4	6	8
468	15,812	3.5808	2	3	3	4	5
469	27,090	7.9945	3	5	7	9	14
470	413,141	3.6890	2	3	3	4	5
471	2,812	9.2649	2	4	7	13	18
472	8,600	3.7783	1	1	2	5	8
473	25,112	1.8500	1	1	1	2	3
474	2,922	11.9521	4	6	9	15	22
475	3,783	7.7275	3	4	6	10	14
476	1,134	4.0908	1	2	3	5	8
477	2,596	11.0882	4	6	9	14	20
478	8,909	6.8587	2	3	6	9	13
479	5,867	3.3936	1	1	2	5	7
480	24,275	9.0228	4	5	7	11	16
481	81,792	5.5520	3	4	5	6	8
482	33,902	4.4797	3	3	4	5	7
483	10,324	3.7260	2	2	3	4	7
484	18,014	2.1959	1	1	2	3	3
485	1,023	10.9101	4	6	9	13	19
486	2,391	7.1861	3	4	6	8	12
487	1,058	5.0888	2	3	4	6	8
488	3,248	4.6918	2	3	3	5	8
489	4,902	2.8499	1	2	3	3	5
490	22,903	4.2505	1	2	3	5	9
491	45,224	2.0655	1	1	1	3	4
492	5,167	8.5982	3	5	7	11	16
493	20,378	4.9773	2	3	4	6	9
494	25,249	3.1465	1	2	3	4	5
495	1,614	10.1691	3	5	8	13	19
496	4,885	5.3793	1	3	4	7	10
497	5,130	2.5558	1	1	2	3	5
498	1,481	7.2552	2	3	6	9	14
499	876	2.9920	1	1	2	3	5
500	1,850	10.4573	3	5	8	13	21
501	5,068	6.0065	2	3	5	8	11
502	5,741	2.8021	1	1	2	3	5
503	914	8.4344	2	4	7	11	16
504	2,808	6.2137	2	3	5	8	11
505	2,256	3.1272	1	1	3	4	6
506	717	3.7992	1	1	3	5	8
507	940	4.5160	1	2	3	5	9
508	1,782	2.0561	1	1	2	3	3
509	349	3.4699	1	1	2	4	7
510	1,058	6.2968	2	3	5	8	12
511	4,312	3.8949	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
512	8,255	2.1474	1	1	2	3	4
513	1,248	4.8205	1	2	4	6	9
514	921	2.6406	1	1	2	3	5
515	3,952	9.8641	3	5	8	12	18
516	12,227	5.9028	2	3	5	8	11
517	11,169	3.3660	1	1	3	5	7
533	818	6.4792	2	3	5	8	12
534	3,463	3.8908	1	2	3	5	7
535	7,263	5.7939	2	3	4	7	11
536	32,802	3.7325	1	3	3	4	6
537	944	4.0911	2	3	3	5	7
538	708	3.0494	1	2	3	4	5
539	3,238	9.4632	3	5	7	11	17
540	4,245	6.7781	2	4	5	8	11
541	1,124	4.8488	1	2	4	6	8
542	5,511	8.3028	3	4	6	10	16
543	16,795	5.6402	2	3	5	7	10
544	6,624	4.0503	2	3	3	5	7
545	3,605	9.0019	2	4	6	11	18
546	6,148	5.3317	2	3	4	7	10
547	3,348	3.5358	1	2	3	4	6
548	579	8.7323	3	4	7	11	17
549	1,215	6.0601	2	3	5	7	11
550	556	4.0108	1	2	3	5	7
551	10,908	6.7836	2	3	5	8	13
552	77,212	3.9754	1	2	3	5	7
553	2,162	5.6300	2	3	4	7	10
554	17,314	3.6410	1	2	3	4	6
555	2,593	4.8481	1	2	4	6	9
556	17,515	3.1807	1	2	3	4	6
557	3,723	6.8571	2	4	5	8	12
558	17,219	4.3499	2	3	4	5	7
559	1,902	7.1420	2	3	5	9	14
560	5,301	4.6403	1	2	4	6	8
561	5,314	2.6314	1	1	2	3	5
562	5,861	5.8555	2	3	5	7	11
563	32,431	3.5741	1	2	3	4	6
564	1,779	6.5509	2	3	5	8	13
565	4,069	4.6319	1	3	4	6	8
566	1,759	3.4179	1	2	3	4	6
573	4,789	12.5780	4	6	9	15	24
574	10,017	8.5081	3	4	7	10	15
575	3,721	5.1774	2	3	4	7	9
576	646	13.0294	3	5	9	17	26
577	2,414	6.1570	1	2	4	8	13
578	2,530	3.2573	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
579	3,778	10.4611	3	5	8	13	20
580	11,548	5.3869	1	2	4	7	11
581	10,753	2.3869	1	1	2	3	5
582	4,901	2.6566	1	1	2	3	5
583	7,581	1.7392	1	1	1	2	3
584	862	4.9617	1	2	4	7	10
585	1,462	2.1382	1	1	1	3	4
592	3,956	8.2786	2	4	6	10	15
593	11,211	5.8634	2	3	5	7	10
594	1,483	4.6703	1	2	4	6	8
595	1,117	7.8809	2	4	6	10	15
596	4,972	4.6072	1	2	4	6	8
597	559	7.5277	2	3	6	9	14
598	1,520	5.4737	1	3	4	7	10
599	185	3.2757	1	1	3	4	5
600	1,034	4.9207	2	3	4	6	9
601	778	3.6157	1	2	3	5	6
602	22,955	6.6712	2	3	5	8	12
603	137,900	4.5353	2	3	4	6	8
604	2,660	5.1549	1	2	4	6	10
605	20,170	3.3178	1	2	3	4	6
606	1,532	6.0091	1	2	4	7	12
607	7,089	3.6430	1	2	3	4	7
614	1,566	6.5447	2	3	5	8	13
615	1,351	2.9704	1	2	3	4	5
616	1,632	15.6746	6	8	13	19	28
617	6,562	7.9334	3	4	7	10	14
618	148	5.1419	2	3	4	6	9
619	840	7.7405	1	2	4	8	17
620	3,287	3.3998	1	2	3	4	6
621	11,451	1.8512	1	1	2	2	3
622	1,161	12.4358	4	6	9	15	23
623	2,541	7.6025	3	4	6	9	13
624	251	4.7649	2	3	4	6	8
625	1,200	6.9017	1	2	5	8	15
626	2,961	3.0523	1	1	2	3	7
627	12,254	1.4115	1	1	1	1	2
628	3,451	10.6140	2	4	8	14	21
629	4,718	8.0377	3	4	7	10	14
630	446	4.4619	1	2	3	6	8
637	18,691	5.9589	2	3	4	7	11
638	54,277	4.0187	1	2	3	5	7
639	24,880	2.8062	1	1	2	3	5
640	56,552	5.0713	1	2	4	6	10
641	187,597	3.5804	1	2	3	4	6
642	1,603	4.7436	1	2	3	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
643	5,944	7.6445	3	4	6	9	14
644	13,584	5.1667	2	3	4	7	9
645	6,422	3.5668	1	2	3	4	6
652	10,210	7.5053	4	5	6	8	13
653	1,695	16.6053	7	9	14	21	30
654	3,722	9.3461	5	6	8	11	15
655	1,275	5.6549	2	4	6	7	9
656	3,223	10.0583	3	5	8	12	20
657	9,015	5.8840	2	3	5	7	10
658	6,807	3.3676	1	2	3	4	5
659	4,058	10.8544	3	5	8	14	21
660	8,540	6.0290	2	3	5	8	12
661	3,862	2.8933	1	2	2	4	5
662	794	10.8363	2	4	8	13	22
663	2,041	5.2156	1	2	4	7	11
664	3,282	1.8525	1	1	1	2	3
665	571	11.3345	3	6	10	14	21
666	2,191	6.3816	1	2	5	9	13
667	2,595	2.3680	1	1	2	3	4
668	3,076	8.9451	2	4	7	12	18
669	14,683	4.3541	1	2	3	6	9
670	8,764	2.2913	1	1	2	3	5
671	799	5.5920	1	2	4	7	11
672	635	2.2000	1	1	2	3	4
673	11,751	9.5646	1	3	7	12	20
674	9,545	6.7385	1	2	5	9	14
675	3,252	2.1125	1	1	1	2	5
682	99,106	6.8064	2	3	5	9	13
683	117,434	4.9378	2	3	4	6	9
684	26,729	3.3482	1	2	3	4	6
685	2,513	3.3979	1	1	2	4	7
686	1,144	7.7736	2	4	6	10	15
687	3,414	4.9889	1	2	4	6	9
688	706	2.8031	1	1	2	3	5
689	60,772	5.7814	2	3	5	7	10
690	213,595	4.0879	2	2	3	5	7
691	999	4.3053	1	2	3	5	9
692	380	2.2421	1	1	2	3	4
693	1,779	5.1793	1	2	4	7	10
694	17,779	2.5757	1	1	2	3	5
695	1,094	5.6307	2	3	4	7	11
696	10,259	3.1686	1	2	3	4	6
697	509	3.1100	1	1	2	4	6
698	23,432	6.7565	2	3	5	8	13
699	31,817	4.6574	1	2	4	6	8
700	8,115	3.2223	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
707	5,392	4.2381	1	2	3	5	8
708	16,899	1.8647	1	1	2	2	3
709	817	5.6793	1	1	3	7	13
710	1,504	1.6642	1	1	1	2	3
711	740	7.2986	1	3	5	9	15
712	424	2.6604	1	1	2	3	5
713	9,760	4.0614	1	2	3	5	9
714	22,626	1.8214	1	1	2	2	3
715	505	6.0554	1	2	4	8	13
716	685	1.3518	1	1	1	1	2
717	734	6.4074	1	3	5	8	13
718	446	2.6121	1	1	2	3	5
722	477	7.7191	2	3	6	10	15
723	1,935	5.0651	1	2	4	6	9
724	276	2.6957	1	1	2	3	5
725	469	6.0874	2	3	4	8	11
726	3,909	3.4804	1	2	3	4	6
727	1,530	6.3399	2	3	5	8	11
728	6,093	4.0883	1	2	3	5	7
729	838	4.6802	1	2	4	6	9
730	276	2.8442	1	1	2	3	5
734	1,520	6.9493	2	3	5	8	14
735	1,138	2.6951	1	1	2	4	5
736	903	13.9989	5	8	11	17	25
737	3,277	6.6628	3	4	6	8	11
738	712	3.5941	2	2	3	4	5
739	905	9.8663	3	5	7	12	20
740	4,462	4.6555	2	3	4	5	8
741	5,393	2.5524	1	1	2	3	4
742	10,807	4.1279	1	2	3	5	8
743	27,700	2.0692	1	1	2	3	3
744	1,625	5.5680	1	2	4	7	11
745	1,265	2.4403	1	1	2	3	5
746	2,621	4.1801	1	2	3	5	8
747	7,265	1.7794	1	1	1	2	3
748	17,103	1.6853	1	1	1	2	3
749	1,052	8.4753	2	4	7	11	16
750	362	2.7901	1	1	2	3	5
754	1,024	8.7656	2	4	7	11	17
755	3,406	5.2980	1	2	4	7	10
756	440	3.0750	1	1	2	4	6
757	1,322	7.7526	3	4	6	9	14
758	2,220	5.7315	2	3	5	7	10
759	978	4.0112	2	2	3	5	7
760	2,269	3.7532	1	2	3	5	7
761	1,138	2.2417	1	1	2	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
765	3,417	4.8674	2	3	4	5	7
766	2,757	3.0812	2	2	3	4	4
767	169	2.6864	2	2	2	3	4
768	8	6.7500	1	2	5	6	13
769	122	5.7459	1	2	4	7	13
770	177	2.0904	1	1	1	2	4
774	1,667	3.2190	2	2	2	3	4
775	5,860	2.3258	1	2	2	3	3
776	588	3.3248	1	2	2	4	6
777	198	2.0505	1	1	2	3	4
778	444	3.2050	1	1	2	3	6
779	121	2.1405	1	1	1	2	4
780	42	1.6190	1	1	1	1	2
781	3,387	3.8432	1	1	3	4	7
782	188	2.6117	1	1	2	3	5
793	3	3.6667	1	1	3	7	7
794	1	1.0000	1	1	1	1	1
799	537	13.3762	4	7	11	17	25
800	686	7.5131	2	4	6	9	15
801	357	3.9076	1	2	3	5	7
802	936	12.1891	3	5	9	14	22
803	1,163	6.5443	2	3	5	8	13
804	764	2.9686	1	1	2	4	6
808	7,983	8.2525	3	4	6	10	16
809	14,321	5.1374	2	3	4	6	9
810	2,170	3.7392	1	2	3	5	7
811	29,074	5.2696	1	2	4	6	10
812	100,179	3.6564	1	2	3	5	7
813	11,471	4.9750	1	2	4	6	10
814	1,597	6.9080	2	3	5	8	13
815	3,792	4.6192	1	2	4	6	8
816	1,532	3.2428	1	2	3	4	6
820	1,269	17.4704	5	8	14	22	34
821	2,061	7.4478	2	3	6	10	15
822	1,738	3.0984	1	1	2	4	6
823	1,872	15.9583	5	8	12	20	30
824	3,134	8.7100	2	4	7	12	17
825	1,442	3.9286	1	1	3	5	8
826	602	14.7741	5	7	11	18	27
827	1,498	6.8892	2	3	6	8	13
828	696	3.7586	1	2	3	5	7
829	1,398	9.3369	2	3	7	11	20
830	385	3.1247	1	1	2	4	6
834	3,703	16.1674	2	5	11	24	37
835	3,050	9.2633	2	3	5	10	25
836	1,201	4.4388	1	2	3	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
837	1,268	23.5733	5	9	23	32	43
838	1,553	12.2788	3	4	6	20	30
839	1,284	5.6830	2	4	5	5	7
840	7,561	10.6359	3	5	8	14	21
841	10,918	6.7759	2	3	5	8	13
842	3,644	4.1715	1	2	3	5	8
843	1,480	8.0122	2	4	6	10	15
844	2,962	5.6283	2	3	4	7	11
845	667	3.7676	1	2	3	5	7
846	2,614	7.9591	2	3	5	9	18
847	22,032	3.4226	1	2	3	4	6
848	1,107	2.9883	1	1	3	4	5
849	1,163	6.0404	2	3	5	6	11
853	39,169	15.7007	5	8	13	19	29
854	8,740	10.0237	4	6	8	12	18
855	337	5.3976	1	2	4	7	10
856	5,929	15.0469	4	7	11	18	29
857	9,810	7.9171	3	4	6	9	15
858	2,325	5.0533	2	3	4	6	9
862	9,500	7.7561	2	4	6	9	15
863	21,677	4.8940	2	3	4	6	8
864	18,172	3.7732	1	2	3	5	7
865	2,269	6.4293	2	3	4	8	13
866	7,441	3.4921	1	2	3	4	6
867	5,314	9.1929	2	4	7	11	18
868	2,854	5.3931	2	3	4	7	10
869	779	3.6393	1	2	3	4	6
870	25,752	15.1737	6	9	13	18	26
871	246,509	7.1936	2	3	6	9	14
872	110,367	5.4377	2	3	5	7	10
876	656	12.6799	2	4	8	14	29
880	8,144	3.0149	1	1	2	4	6
881	4,536	4.2377	1	2	3	5	8
882	1,797	4.2966	1	2	3	5	8
883	863	7.7034	1	3	5	8	15
884	18,110	5.3720	2	3	4	6	9
885	88,160	7.3601	2	3	6	9	13
886	525	6.1657	1	2	4	6	12
887	466	4.0494	1	2	3	5	7
894	4,520	2.9412	1	1	2	3	4
895	6,273	10.9396	3	4	6	8	9
896	6,925	6.5217	2	3	5	8	12
897	36,863	3.9730	1	2	3	4	6
901	937	14.1206	3	5	9	17	30
902	1,890	7.4889	2	3	6	9	14
903	1,027	4.4450	1	2	3	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
904	1,895	11.1135	2	4	7	13	23
905	763	4.5242	1	2	4	6	9
906	707	3.0905	1	1	2	3	6
907	8,654	11.1347	2	5	8	14	22
908	9,017	6.3353	2	3	5	8	12
909	4,760	3.3786	1	1	3	4	7
913	872	5.6239	1	3	4	6	11
914	5,458	3.1999	1	2	3	4	6
915	1,429	5.0539	1	2	4	6	10
916	5,634	2.1132	1	1	2	3	4
917	19,117	5.1092	1	2	4	6	10
918	36,755	2.7429	1	1	2	3	5
919	10,767	6.2020	2	3	4	8	12
920	15,246	4.2676	1	2	3	5	8
921	7,314	2.8138	1	1	2	3	5
922	1,046	5.4312	1	2	4	7	10
923	3,201	3.2471	1	1	2	4	6
927	188	28.2128	8	13	23	39	55
928	948	14.8597	3	7	12	20	29
929	366	7.6721	1	3	6	10	15
933	138	5.2319	1	1	1	5	12
934	608	5.8257	1	2	4	7	11
935	2,111	5.2321	1	2	3	6	10
939	718	9.9624	2	4	7	13	21
940	1,637	5.3769	1	2	4	7	12
941	1,455	2.5904	1	1	2	3	5
945	5,971	10.1921	4	6	8	11	15
946	2,809	7.4938	3	5	6	7	8
947	12,298	4.9270	1	2	4	6	9
948	55,443	3.4200	1	2	3	4	6
949	640	4.2969	1	1	2	4	7
950	276	2.7572	1	1	2	3	4
951	1,028	4.5360	1	1	2	3	6
955	443	12.6456	3	5	9	17	24
956	4,421	8.4180	4	5	7	10	15
957	1,436	14.2806	3	7	12	19	27
958	1,214	9.5486	3	5	8	12	16
959	200	5.5800	2	3	5	7	10
963	1,769	8.6733	1	3	7	12	18
964	2,904	5.6295	2	3	5	7	10
965	913	3.7558	1	2	3	5	7
969	631	17.1236	4	7	13	22	35
970	102	8.6569	1	4	7	12	17
974	5,213	9.6277	2	4	7	12	19
975	4,509	6.6378	2	3	5	8	12
976	1,529	4.4173	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
977	3,547	4.8765	1	2	4	6	9
981	25,561	14.1288	4	7	11	18	26
982	19,665	8.6927	3	4	7	11	16
983	4,894	4.2284	1	2	3	6	9
984	505	13.2911	4	7	12	17	24
985	1,056	9.0369	2	4	8	12	17
986	447	4.0559	1	1	2	6	9
987	7,986	12.1990	3	6	10	15	23
988	10,939	7.4428	2	3	6	10	14
989	3,950	3.5337	1	1	2	5	7
	10,957,307						

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2010

State	Urban	Rural
Alabama	0.247	0.318
Alaska	0.342	0.654
Arizona	0.27	0.357
Arkansas	0.313	0.328
California	0.218	0.277
Colorado	0.279	0.413
Connecticut	0.39	0.517
Delaware	0.483	0.447
District of Columbia*	0.325	----
Florida	0.222	0.251
Georgia	0.311	0.374
Hawaii	0.375	0.48
Idaho	0.454	0.546
Illinois	0.293	0.363
Indiana	0.37	0.429
Iowa	0.338	0.418
Kansas	0.28	0.408
Kentucky	0.368	0.353
Louisiana	0.295	0.334
Maine	0.487	0.478
Maryland	0.719	0.767
Massachusetts	0.468	0.963
Michigan	0.371	0.441
Minnesota	0.383	0.509
Mississippi	0.285	0.336
Missouri	0.317	0.34
Montana	0.401	0.461
Nebraska	0.334	0.44
Nevada	0.202	0.432
New Hampshire	0.422	0.42
New Jersey*	0.175	----
New Mexico	0.341	0.357
New York	0.344	0.51
North Carolina	0.374	0.38
North Dakota	0.445	0.343
Ohio	0.317	0.486
Oklahoma	0.294	0.366

State	Urban	Rural
Oregon	0.432	0.397
Pennsylvania	0.254	0.409
Puerto Rico*	0.489	----
Rhode Island*	0.373	----
South Carolina	0.274	0.303
South Dakota	0.322	0.398
Tennessee	0.282	0.346
Texas	0.245	0.328
Utah	0.396	0.586
Vermont	0.558	0.632
Virginia	0.341	0.346
Washington	0.343	0.445
West Virginia	0.438	0.465
Wisconsin	0.391	0.441
Wyoming	0.393	0.523

*All counties in the State or Territory are classified as urban.

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2010

State	Ratio
Alabama	0.024
Alaska	0.039
Arizona	0.027
Arkansas	0.024
California	0.015
Colorado	0.029
Connecticut	0.026
Delaware	0.035
District of Columbia	0.018
Florida	0.022
Georgia	0.027
Hawaii	0.029
Idaho	0.038
Illinois	0.025
Indiana	0.037
Iowa	0.028
Kansas	0.03
Kentucky	0.03
Louisiana	0.025
Maine	0.03
Maryland	0.059
Massachusetts	0.033
Michigan	0.031
Minnesota	0.031
Mississippi	0.026
Missouri	0.028
Montana	0.034
Nebraska	0.034
Nevada	0.023
New Hampshire	0.034
New Jersey	0.013
New Mexico	0.034
New York	0.026
North Carolina	0.032
North Dakota	0.029
Ohio	0.028
Oklahoma	0.025
Oregon	0.037

State	Ratio
Pennsylvania	0.021
Puerto Rico	0.041
Rhode Island	0.02
South Carolina	0.026
South Dakota	0.027
Tennessee	0.025
Texas	0.025
Utah	0.037
Vermont	0.045
Virginia	0.033
Washington	0.028
West Virginia	0.031
Wisconsin	0.038
Wyoming	0.04

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS (CCRs) FOR LTCHs—DECEMBER 2009

State	Urban	Rural
Alabama	0.268	0.347
Alaska	0.373	0.745
Arizona	0.296	0.389
Arkansas	0.334	0.357
California	0.232	0.298
Colorado	0.306	0.46
Connecticut	0.41	0.566
Delaware	0.517	0.483
District of Columbia*	0.343	----
Florida	0.243	0.308
Georgia	0.335	0.409
Hawaii	0.399	0.511
Idaho	0.491	0.585
Illinois	0.317	0.392
Indiana	0.404	0.48
Iowa	0.364	0.462
Kansas	0.307	0.446
Kentucky	0.397	0.386
Louisiana	0.32	0.362
Maine	0.519	0.505
Maryland**	0.327	0.42
Massachusetts	0.498	1.06
Michigan	0.402	0.478
Minnesota	0.412	0.554
Mississippi	0.312	0.364
Missouri	0.341	0.373
Montana	0.431	0.503
Nebraska	0.367	0.479
Nevada	0.224	0.503
New Hampshire	0.456	0.449
New Jersey*	0.189	----
New Mexico	0.375	0.393
New York	0.368	0.544
North Carolina	0.405	0.408
North Dakota	0.459	0.371
Ohio	0.344	0.528
Oklahoma	0.303	0.396
Oregon	0.458	0.433
Pennsylvania	0.273	0.443

State	Urban	Rural
Puerto Rico*	0.531	----
Rhode Island*	0.393	----
South Carolina	0.3	0.325
South Dakota	0.346	0.431
Tennessee	0.305	0.382
Texas	0.267	0.372
Utah	0.435	0.637
Vermont	0.608	0.67
Virginia	0.373	0.378
Washington	0.374	0.476
West Virginia	0.462	0.5
Wisconsin	0.42	0.481
Wyoming	0.429	0.568

*All counties in the State or Territory are classified as urban. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of July 2010.

**National average IPPS total CCRs, as discussed in section V.C.2. of this Addendum.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS--FY 2011

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
010001	20020	10500	
010005	01	13820	
010009	19460	26620	
010022	01	12060	
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010046	23460	13820	
010052	01	33860	
010054	19460	26620	
010055	20020	37460	
010059	19460	26620	
010061	01	16860	
010065	01	13820	
010083	01	33660	
010085	19460	26620	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	46220	
010126	01	33860	
010143	01	26620	
010158	01	19460	
010164	01	13820	
020008	02	11260	
030033	03	38060	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	26	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	26	
040071	38220	30780	
040076	04	26300	LUGAR
040080	04	27860	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
040085	04	32820	
040088	04	33740	
040119	04	30780	
050002	36084	41940	
050006	05	39820	
050009	34900	42220	
050013	34900	42220	
050014	05	40900	
050022	40140	42044	
050038	41940	42100	
050042	05	39820	
050043	36084	41940	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050075	36084	41940	
050082	37100	31084	
050084	44700	40900	
050089	40140	31084	
050090	42220	36084	
050095	36084	41940	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050125	41940	42100	
050129	40140	31084	
050131	41884	36084	
050136	42220	36084	
050140	40140	31084	
050150	05	40900	
050152	41884	36084	
050153	41940	42100	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	36084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050188	41940	42100	
050193	42044	31084	
050195	36084	41940	
050197	41884	41940	
050211	36084	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	
050245	40140	31084	
050264	36084	41940	
050272	40140	31084	
050279	40140	31084	
050283	36084	41940	
050291	42220	36084	
050292	40140	42044	
050300	40140	31084	
050305	36084	41940	
050308	41940	42100	
050320	36084	41940	
050327	40140	31084	
050329	40140	42044	
050334	41500	41940	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050366	05	40900	
050367	46700	36084	
050380	41940	42100	
050385	42220	36084	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050488	36084	41940	
050510	41884	36084	
050512	36084	41940	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050547	42220	36084	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	31084	
050616	37100	31084	
050662	41940	42100	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050688	41940	42100	
050690	42220	36084	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050748	44700	33700	
050749	37100	31084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050758	40140	31084	
060001	24540	19740	
060003	14500	19740	
060023	24300	19740	
060027	14500	19740	
060031	17820	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
060118	06	19740	
060121	24540	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	LUGAR
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070021	07	25540	LUGAR
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090004	47894	13644	
100002	48424	22744	
100014	19660	36740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
100017	19660	36740	
100022	33124	22744	
100023	10	45300	
100024	10	33124	
100045	19660	36740	
100047	39460	35840	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	35840	
100080	48424	22744	
100081	10	18880	LUGAR
100105	42680	38940	
100109	10	36740	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100157	29460	45300	
100160	10	33124	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	23540	
100234	48424	22744	
100236	39460	35840	
100249	10	45300	
100252	10	38940	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100290	10	36740	
100292	10	18880	LUGAR
110001	19140	16860	
110002	11	31420	
110016	11	17980	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
110023	11	12060	
110029	23580	12060	
110038	11	46660	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110095	11	10500	
110105	11	10500	
110112	11	10500	
110122	46660	45220	
110125	11	31420	
110146	11	15260	
110150	11	31420	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
110190	11	47580	
130002	13	14260	
130003	30300	28420	
130049	17660	44060	
130067	13	26820	LUGAR
140008	16974	29404	
140010	16974	29404	
140012	14	16974	
140015	14	41180	
140018	16974	29404	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140048	16974	29404	
140049	16974	29404	
140051	16974	29404	
140054	16974	29404	
140058	14	44100	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140062	16974	29404	
140063	16974	29404	
140064	14	37900	
140065	16974	29404	
140068	16974	29404	
140075	16974	29404	
140080	16974	29404	
140082	16974	29404	
140083	16974	29404	
140088	16974	29404	
140094	16974	29404	
140095	16974	29404	
140103	16974	29404	
140110	14	16974	
140114	16974	29404	
140115	16974	29404	
140116	16974	29404	
140117	16974	29404	
140118	16974	29404	
140119	16974	29404	
140124	16974	29404	
140133	16974	29404	
140135	19500	16580	
140150	16974	29404	
140151	16974	29404	
140155	28100	16974	
140158	16974	29404	
140160	14	40420	
140161	14	16974	
140164	14	16020	
140166	19500	16580	
140172	16974	29404	
140176	16974	29404	
140177	16974	29404	
140179	16974	29404	
140180	16974	29404	
140181	16974	29404	
140182	16974	29404	
140186	28100	16974	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140191	16974	29404	
140197	16974	29404	
140206	16974	29404	
140207	16974	29404	
140208	16974	29404	
140223	16974	29404	
140224	16974	29404	
140240	16974	29404	
140250	16974	29404	
140251	16974	29404	
140252	16974	29404	
140258	16974	29404	
140276	16974	29404	
140281	16974	29404	
140290	16974	29404	
140300	16974	29404	
140301	16974	29404	
140303	16974	29404	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150018	21140	43780	
150023	45460	26900	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	45460	
150048	15	17140	
150051	14020	26900	
150064	15	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150089	34620	11300	
150090	23844	16974	
150091	15	23060	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150125	23844	16974	
150126	23844	16974	
150133	15	43780	
150146	15	21140	
150165	23844	16974	
150166	23844	16974	
150170	23844	16974	
160001	16	19780	
160016	16	11180	
160057	16	26980	
160064	16	24	
160080	16	19340	
160147	16	11180	
170006	17	27900	
170013	17	28	
170020	17	48620	
170033	17	48620	
170058	17	28140	
170068	17	11100	
170142	31740	45820	
170175	17	48620	
180002	18	49	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	14540	
180020	18	49	
180024	18	21060	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	
180048	18	31140	
180050	18	28700	
180069	18	26580	
180078	18	26580	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
180080	18	28940	
180102	18	16020	
180104	18	16020	
180116	18	16020	
180124	14540	34980	
180127	18	17140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190017	19	29180	
190086	19	33740	
190106	19	10780	
190144	19	43340	
190164	19	45	
190167	19	29180	
190190	19	33740	
190218	19	43340	
190257	19	33740	
200002	20	38860	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
220001	49340	14484	
220002	15764	14484	
220008	39300	14484	
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
220070	15764	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220082	15764	14484	
220084	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	37764	14484	
220175	15764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	12980	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	11460	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230089	19804	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	24340	
230106	24340	34740	
230121	23	29620	LUGAR
230130	47644	22420	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230222	23	13020	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	22420	
230257	47644	19804	
230264	47644	19804	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	11460	
230297	19804	11460	
230301	47644	22420	
230302	47644	22420	
230B04	47644	22420	
230B95	19804	11460	
240036	41060	33460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
240069	24	33460	
240071	24	33460	
240187	24	33460	
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250069	25	46220	
250078	25620	25060	
250079	25	27140	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250095	25	27140	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	27620	
260017	26	27620	
260022	26	17860	
260025	26	41180	
260074	26	17860	
260094	26	44180	
260113	26	14	
260116	26	14	
260119	26	16020	
260175	26	28140	
260186	26	27620	
270003	27	24500	
270012	24500	33540	
270017	27	33540	
270051	27	33540	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
280009	28	30700	
280023	28	30700	
280065	28	24540	
280077	28	30700	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290019	16180	39900	
300011	31700	15764	
300012	31700	15764	
300017	40484	37764	
300019	30	44140	
300020	31700	15764	
300029	40484	37764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310022	15804	37964	
310029	15804	37964	
310031	15804	20764	
310038	20764	35644	
310039	20764	35644	
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310086	15804	37964	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
330008	33	15380	LUGAR
330023	39100	35644	
330027	35004	35644	
330073	33	40380	LUGAR
330079	33	47	
330090	21300	27060	
330094	33	38340	
330106	35004	35644	
330126	39100	35644	
330136	33	10580	
330157	33	45060	
330167	35004	35644	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330198	35004	35644	
330213	33	46540	
330224	28740	39100	
330225	35004	35644	
330229	33	21500	
330239	33	21500	
330250	33	15540	
330259	35004	35644	
330277	33	27060	
330331	35004	35644	
330332	35004	35644	
330372	35004	35644	
330386	33	35084	
340004	24660	49180	
340008	34	26580	
340013	34	16740	
340015	34	16740	
340021	34	16740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
340023	11700	24860	
340027	34	24780	
340037	34	16740	
340039	34	49180	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340085	34	24660	LUGAR
340091	24660	49180	
340096	34	24660	LUGAR
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350006	35	13900	
360010	36	15940	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	31900	
360054	36	26580	
360055	49660	17460	
360065	36	17460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
360078	10420	17460	
360086	44220	19380	
360095	36	45780	
360109	36	18140	
360112	45780	33780	
360121	36	45780	
360133	19380	17140	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360211	44600	38300	
360241	10420	17460	
360245	36	17460	LUGAR
370004	37	27900	
370006	37	46140	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370019	37	45	
370020	37	36420	
370022	37	30020	
370025	37	46140	
370026	37	36420	
370030	37	46140	
370047	37	36420	
370099	37	36420	
370113	37	22220	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
390016	39	38300	
390030	39	39740	LUGAR
390031	39	39740	LUGAR
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390067	25420	29540	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	38300	
390091	39	49660	
390093	39	49660	
390110	27780	38300	
390113	39	21500	
390133	10900	37964	
390138	39	25420	
390151	39	13644	
390162	10900	35084	
390185	42540	10900	
390313	39	39740	LUGAR
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16700	
420027	11340	24860	
420030	42	16700	
420036	42	17900	
420039	42	43900	LUGAR
420067	42	42340	
420068	42	12260	
420069	42	44940	LUGAR

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420101	42	42340	
430012	43	43620	
440002	27180	32820	
440018	27740	28700	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440058	44	26620	
440059	44	34980	
440067	34100	28700	
440068	44	16860	
440073	44	34980	
440144	44	34980	
440151	44	34980	
440174	44	32820	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	30980	LUGAR
450039	23104	19124	
450064	23104	19124	
450080	45	19124	
450087	23104	19124	
450092	45	29700	
450099	45	11100	
450135	23104	19124	
450137	23104	19124	
450144	45	33260	
450147	47020	18580	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450211	45	30980	
450214	45	26420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450370	45	26420	
450389	45	19124	LUGAR
450400	45	17780	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450547	45	19124	
450563	23104	19124	
450565	45	23104	
450596	45	23104	
450604	45	41700	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450872	23104	19124	
450880	23104	19124	
450886	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460026	46	39340	
460039	46	36260	
460041	36260	41620	
460042	36260	41620	
470001	47	15540	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	16820	
490042	13980	40220	
490043	47894	13644	
490063	47894	13644	
490066	47260	40060	
490079	49	49180	
490101	47894	13644	
490107	47894	13644	
490122	47894	13644	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510046	51	49	
510047	51	34060	
510050	48540	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	
520013	20740	33460	
520021	29404	16974	
520028	52	31540	LUGAR

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	33340	
520095	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
520189	29404	16974	
530014	16940	24540	

TABLE 9C.–HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT–FY 2011

Provider No.	Geographic CBSA	Redesignated Rural Area
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170074	31740	17
170137	29940	17
180016	31140	18
180038	36980	18
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260034	28140	26
260047	27620	26
260195	44180	26
300023	40484	33
330215	46540	33
330235	33	33
330268	10580	33
340010	24140	34
340121	48900	34
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390233	49620	39
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
490116	13980	49
500148	48300	50

TABLE 10.— GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG)—MARCH 2010[1]

MS-DRG	Number of Cases	Threshold
1	907	$434,245
2	333	$240,232
3	21,932	$280,834
4	21,377	$171,837
5	889	$181,631
6	408	$106,603
7	469	$180,685
8	508	$111,800
10	137	$87,191
11	1,465	$84,611
12	1,963	$62,285
13	1,008	$44,014
14	446	$173,221
15	1,371	$110,828
20	1,081	$161,767
21	468	$124,259
22	146	$85,874
23	4,406	$96,764
24	1,708	$70,333
25	11,578	$86,631
26	11,464	$61,699
27	12,575	$49,489
28	1,850	$90,885
29	3,505	$55,101
30	3,432	$35,818
31	1,169	$69,659
32	2,808	$42,884
33	3,346	$35,451
34	818	$71,961
35	2,329	$51,071
36	5,711	$43,574
37	4,943	$62,277
38	14,446	$39,441
39	43,741	$29,380
40	4,815	$69,423
41	7,549	$46,033

MS-DRG	Number of Cases	Threshold
42	3,807	$39,316
52	1,250	$35,010
53	487	$24,212
54	7,203	$33,761
55	13,021	$29,356
56	9,282	$33,807
57	43,183	$23,053
58	893	$33,327
59	3,245	$26,683
60	3,512	$20,846
61	2,265	$63,317
62	3,736	$49,373
63	1,306	$43,140
64	60,920	$39,190
65	112,506	$31,542
66	66,435	$23,769
67	1,387	$35,073
68	10,359	$26,739
69	92,456	$21,784
70	9,641	$38,473
71	13,705	$29,897
72	4,836	$21,740
73	8,924	$30,863
74	31,535	$24,268
75	1,345	$38,691
76	660	$26,901
77	1,517	$38,495
78	2,120	$29,153
79	773	$21,987
80	1,625	$29,586
81	5,863	$20,738
82	2,372	$40,097
83	2,594	$32,688
84	2,540	$25,202
85	7,305	$40,772
86	14,305	$30,370
87	13,004	$21,699
88	870	$35,610
89	3,155	$27,526
90	2,481	$20,786
91	8,734	$34,747
92	19,740	$25,249

MS-DRG	Number of Cases	Threshold
93	13,201	$19,449
94	1,426	$65,792
95	1,185	$49,565
96	540	$42,502
97	1,186	$61,456
98	1,063	$42,348
99	422	$33,115
100	19,251	$33,637
101	56,024	$21,484
102	1,284	$27,641
103	12,514	$20,151
113	639	$40,406
114	431	$26,196
115	849	$31,885
116	455	$31,888
117	549	$21,050
121	744	$23,633
122	523	$15,971
123	2,670	$21,955
124	738	$28,841
125	4,273	$18,988
129	1,508	$48,976
130	939	$34,737
131	1,132	$46,345
132	745	$33,424
133	2,242	$36,924
134	2,622	$24,387
135	466	$42,963
136	351	$28,285
137	890	$31,653
138	746	$22,447
139	1,361	$25,472
146	734	$41,764
147	1,362	$29,480
148	552	$23,055
149	33,589	$18,807
150	1,162	$29,226
151	6,159	$16,053
152	2,298	$25,939
153	11,461	$17,571
154	2,458	$32,534
155	6,150	$25,001

MS-DRG	Number of Cases	Threshold
156	3,513	$17,470
157	1,374	$33,896
158	3,705	$24,494
159	1,458	$16,289
163	13,429	$92,474
164	18,789	$56,614
165	10,516	$43,737
166	23,092	$68,109
167	19,774	$46,238
168	4,387	$34,990
175	14,073	$38,408
176	36,633	$29,043
177	68,096	$42,241
178	71,786	$34,277
179	16,033	$25,958
180	20,621	$38,793
181	26,178	$31,187
182	2,834	$23,827
183	2,662	$35,329
184	5,183	$26,627
185	2,185	$18,859
186	10,686	$35,963
187	10,940	$29,659
188	3,291	$21,555
189	94,000	$32,121
190	136,797	$30,807
191	150,301	$26,417
192	134,340	$19,737
193	103,862	$34,826
194	206,953	$27,354
195	86,964	$19,374
196	6,956	$36,218
197	6,785	$29,750
198	3,045	$22,571
199	3,790	$38,729
200	8,673	$27,771
201	2,745	$19,061
202	38,878	$23,055
203	28,973	$16,710
204	23,374	$19,911
205	6,673	$30,904
206	19,971	$21,524

MS-DRG	Number of Cases	Threshold
207	36,206	$96,662
208	74,943	$48,685
215	177	$197,565
216	9,531	$182,613
217	6,914	$133,364
218	1,220	$112,405
219	12,757	$149,444
220	16,859	$110,276
221	4,462	$96,359
222	2,753	$167,255
223	3,841	$131,602
224	2,736	$152,310
225	4,479	$125,719
226	7,259	$124,233
227	30,034	$103,955
228	2,305	$142,545
229	2,844	$101,007
230	806	$79,269
231	1,350	$165,608
232	1,219	$131,481
233	15,280	$140,586
234	27,390	$106,146
235	9,464	$111,951
236	25,454	$83,813
237	22,095	$98,558
238	40,046	$66,101
239	10,860	$70,090
240	10,778	$47,663
241	1,549	$34,093
242	17,876	$73,344
243	41,219	$58,653
244	44,714	$48,782
245	3,963	$84,900
246	30,895	$74,642
247	143,690	$54,799
248	14,355	$69,420
249	46,331	$51,231
250	7,651	$64,700
251	36,366	$49,826
252	40,559	$57,835
253	44,579	$53,429
254	38,311	$41,802

MS-DRG	Number of Cases	Threshold
255	2,482	$45,768
256	3,195	$35,494
257	394	$25,161
258	762	$59,622
259	5,040	$43,543
260	1,769	$63,839
261	3,898	$37,685
262	2,417	$30,338
263	517	$35,655
264	22,458	$46,679
265	1,714	$47,659
280	69,980	$39,490
281	53,379	$31,733
282	34,872	$24,367
283	12,645	$36,266
284	4,028	$25,976
285	1,426	$17,208
286	25,184	$47,068
287	134,625	$34,930
288	2,679	$54,285
289	1,196	$39,615
290	240	$31,203
291	176,278	$33,680
292	248,137	$26,745
293	117,949	$18,319
294	1,546	$26,111
295	874	$15,647
296	1,917	$31,226
297	762	$21,036
298	370	$13,581
299	21,212	$32,155
300	48,392	$24,880
301	28,761	$17,012
302	7,755	$26,119
303	52,448	$17,051
304	2,864	$28,173
305	33,320	$17,776
306	3,078	$32,067
307	6,028	$21,707
308	56,608	$30,569
309	107,651	$22,974
310	127,822	$16,117

MS-DRG	Number of Cases	Threshold
311	15,707	$15,028
312	164,947	$20,561
313	169,249	$17,054
314	61,143	$36,453
315	31,566	$26,084
316	10,661	$17,666
326	11,323	$100,038
327	10,427	$56,127
328	8,536	$37,088
329	46,053	$93,370
330	60,286	$55,007
331	24,223	$40,753
332	1,602	$86,827
333	5,288	$53,532
334	3,027	$39,164
335	7,048	$80,849
336	13,571	$51,477
337	7,645	$38,166
338	1,283	$66,771
339	2,986	$46,480
340	3,035	$35,170
341	906	$51,011
342	2,901	$37,261
343	6,446	$28,320
344	914	$61,169
345	3,050	$40,209
346	2,589	$30,770
347	1,477	$46,158
348	4,253	$33,994
349	4,036	$22,321
350	1,676	$49,482
351	4,531	$35,490
352	6,446	$24,273
353	3,228	$54,617
354	9,551	$38,734
355	12,936	$28,045
356	7,893	$69,691
357	7,603	$47,181
358	2,044	$35,035
368	3,304	$38,781
369	5,624	$29,781
370	1,776	$21,455

MS-DRG	Number of Cases	Threshold
371	22,527	$40,135
372	34,664	$31,161
373	11,188	$22,331
374	8,067	$41,336
375	17,153	$31,518
376	2,535	$24,404
377	48,249	$37,454
378	138,450	$27,315
379	50,738	$19,552
380	2,926	$41,150
381	6,193	$30,795
382	2,706	$23,160
383	1,129	$32,602
384	7,393	$25,019
385	2,206	$39,912
386	9,038	$29,099
387	4,129	$22,146
388	18,643	$35,848
389	54,825	$25,881
390	39,776	$18,232
391	45,134	$29,680
392	248,631	$20,958
393	21,573	$35,248
394	49,036	$27,559
395	20,047	$19,463
405	4,356	$94,902
406	5,109	$57,667
407	1,925	$43,571
408	1,492	$76,268
409	1,446	$53,357
410	474	$40,046
411	782	$75,017
412	838	$57,460
413	524	$44,552
414	4,697	$69,885
415	5,774	$48,153
416	3,984	$35,009
417	17,747	$55,518
418	27,480	$43,966
419	28,223	$34,296
420	711	$69,211
421	908	$43,258

MS-DRG	Number of Cases	Threshold
422	234	$34,441
423	1,486	$78,374
424	802	$51,529
425	86	$39,079
432	12,406	$36,533
433	8,081	$26,786
434	398	$17,634
435	12,193	$39,619
436	12,588	$31,248
437	2,181	$27,130
438	14,974	$38,269
439	27,894	$28,968
440	20,546	$20,564
441	14,420	$36,621
442	18,594	$26,589
443	4,681	$18,613
444	12,604	$36,356
445	19,019	$30,426
446	12,775	$22,512
453	1,132	$182,692
454	3,077	$132,948
455	2,469	$102,744
456	1,130	$164,516
457	3,192	$114,426
458	1,561	$93,166
459	3,821	$114,004
460	61,691	$76,529
461	636	$95,750
462	11,335	$71,162
463	5,297	$72,652
464	8,717	$52,913
465	2,706	$39,867
466	3,703	$87,195
467	20,146	$65,733
468	15,777	$55,334
469	27,068	$67,299
470	412,246	$49,549
471	2,809	$88,964
472	8,590	$59,484
473	25,031	$49,259
474	2,921	$58,249
475	3,780	$40,794

MS-DRG	Number of Cases	Threshold
476	1,133	$26,002
477	2,596	$65,108
478	8,906	$51,186
479	5,865	$41,443
480	24,261	$61,969
481	81,675	$45,348
482	33,813	$39,284
483	10,312	$54,770
484	17,960	$47,483
485	1,022	$63,293
486	2,389	$47,100
487	1,056	$38,013
488	3,242	$39,904
489	4,891	$31,977
490	22,896	$41,626
491	45,102	$27,812
492	5,163	$60,846
493	20,358	$43,967
494	25,195	$34,948
495	1,614	$54,469
496	4,879	$38,810
497	5,123	$29,492
498	1,480	$43,377
499	875	$26,447
500	1,848	$55,259
501	5,063	$37,568
502	5,734	$27,688
503	914	$46,218
504	2,807	$37,301
505	2,256	$29,136
506	716	$31,618
507	940	$43,481
508	1,782	$35,680
509	349	$34,621
510	1,057	$48,362
511	4,310	$38,156
512	8,239	$28,922
513	1,248	$33,152
514	920	$22,905
515	3,952	$61,716
516	12,225	$45,041
517	11,158	$37,652

MS-DRG	Number of Cases	Threshold
533	818	$32,358
534	3,460	$18,488
535	7,260	$30,780
536	32,783	$17,853
537	944	$21,930
538	707	$16,133
539	3,237	$38,638
540	4,242	$31,087
541	1,124	$22,751
542	5,508	$39,262
543	16,786	$29,624
544	6,621	$20,148
545	3,601	$42,580
546	6,143	$28,738
547	3,344	$20,085
548	578	$39,621
549	1,215	$29,575
550	555	$20,310
551	10,903	$35,750
552	77,153	$22,274
553	2,150	$28,226
554	17,287	$17,720
555	2,590	$27,936
556	17,502	$18,051
557	3,722	$35,286
558	17,209	$23,595
559	1,899	$34,415
560	5,300	$24,964
561	5,307	$16,072
562	5,857	$31,319
563	32,421	$18,265
564	1,779	$32,772
565	4,064	$24,269
566	1,758	$17,800
573	4,788	$50,542
574	10,014	$37,184
575	3,719	$27,509
576	644	$63,202
577	2,414	$37,754
578	2,529	$28,880
579	3,776	$52,443
580	11,546	$35,468

MS-DRG	Number of Cases	Threshold
581	10,745	$26,778
582	4,896	$29,747
583	7,560	$24,267
584	862	$36,952
585	1,459	$30,205
592	3,953	$34,195
593	11,208	$25,280
594	1,482	$17,532
595	1,114	$35,853
596	4,967	$22,362
597	559	$34,968
598	1,519	$28,537
599	185	$18,944
600	1,034	$25,106
601	778	$17,823
602	22,941	$32,031
603	137,791	$21,037
604	2,660	$30,594
605	20,161	$19,580
606	1,531	$28,668
607	7,082	$17,523
614	1,566	$52,876
615	1,350	$38,331
616	1,630	$73,334
617	6,557	$41,763
618	148	$31,392
619	840	$66,833
620	3,281	$45,226
621	11,420	$39,418
622	1,161	$51,332
623	2,540	$37,658
624	251	$27,170
625	1,200	$47,825
626	2,958	$33,033
627	12,193	$22,852
628	3,450	$60,959
629	4,714	$46,582
630	446	$36,422
637	18,690	$32,234
638	54,251	$21,744
639	24,864	$14,934
640	56,538	$27,789

MS-DRG	Number of Cases	Threshold
641	187,502	$18,502
642	1,603	$26,187
643	5,943	$37,831
644	13,581	$28,528
645	6,414	$20,136
652	10,206	$69,446
653	1,695	$103,526
654	3,717	$62,937
655	1,275	$45,981
656	3,219	$69,622
657	9,011	$47,214
658	6,794	$38,290
659	4,057	$62,116
660	8,536	$42,838
661	3,858	$35,296
662	794	$54,224
663	2,041	$35,553
664	3,279	$30,167
665	571	$54,953
666	2,190	$37,500
667	2,593	$21,648
668	3,075	$50,865
669	14,675	$33,924
670	8,752	$21,741
671	799	$34,868
672	633	$21,959
673	11,749	$52,536
674	9,543	$45,904
675	3,249	$37,269
682	99,060	$34,669
683	117,393	$26,883
684	26,713	$17,930
685	2,509	$22,911
686	1,144	$38,658
687	3,412	$28,835
688	705	$18,931
689	60,753	$29,890
690	213,524	$20,821
691	997	$39,723
692	380	$29,377
693	1,778	$34,011

MS-DRG	Number of Cases	Threshold
694	17,760	$21,450
695	1,093	$29,370
696	10,252	$17,381
697	509	$21,088
698	23,414	$34,055
699	31,796	$26,373
700	8,108	$18,232
707	5,391	$43,551
708	16,866	$36,159
709	817	$38,918
710	1,503	$32,486
711	739	$38,867
712	424	$23,105
713	9,757	$30,924
714	22,569	$17,966
715	505	$39,925
716	685	$32,503
717	734	$35,429
718	446	$22,030
722	477	$34,256
723	1,933	$27,779
724	276	$17,297
725	468	$30,772
726	3,907	$18,897
727	1,529	$31,681
728	6,091	$20,560
729	836	$25,783
730	276	$17,460
734	1,520	$49,324
735	1,137	$33,179
736	903	$83,470
737	3,274	$47,200
738	711	$34,082
739	905	$63,570
740	4,458	$39,308
741	5,381	$30,656
742	10,803	$35,874
743	27,629	$25,402
744	1,623	$35,398
745	1,263	$24,085
746	2,619	$34,032

MS-DRG	Number of Cases	Threshold
747	7,244	$24,914
748	17,063	$25,408
749	1,052	$49,175
750	362	$25,774
754	1,022	$40,025
755	3,404	$28,901
756	440	$18,265
757	1,322	$36,079
758	2,220	$29,154
759	978	$20,075
760	2,268	$22,173
761	1,135	$15,266
765	3,416	$23,396
766	2,753	$15,950
767	168	$18,876
769	122	$36,289
770	177	$19,526
774	1,665	$13,966
775	5,850	$10,155
776	588	$17,142
777	197	$22,190
778	444	$10,944
779	121	$14,296
780	42	$5,027
781	3,387	$16,074
782	188	$10,992
799	537	$93,801
800	686	$56,226
801	356	$39,392
802	935	$61,181
803	1,162	$41,905
804	764	$30,381
808	7,976	$42,063
809	14,309	$29,974
810	2,165	$25,051
811	29,067	$29,896
812	100,121	$21,370
813	11,434	$30,788
814	1,595	$35,777
815	3,792	$27,743
816	1,528	$19,965

MS-DRG	Number of Cases	Threshold
820	1,268	$101,585
821	2,060	$50,233
822	1,736	$33,712
823	1,872	$83,644
824	3,132	$50,598
825	1,442	$33,753
826	602	$86,073
827	1,497	$47,782
828	694	$36,506
829	1,398	$51,566
830	384	$31,420
834	3,700	$70,199
835	3,043	$39,872
836	1,199	$26,518
837	1,266	$106,271
838	1,553	$53,954
839	1,282	$31,359
840	7,556	$51,514
841	10,908	$36,242
842	3,637	$28,006
843	1,480	$38,892
844	2,961	$30,255
845	666	$23,011
846	2,613	$42,088
847	22,015	$29,252
848	1,106	$24,344
849	1,161	$32,275
853	39,157	$91,531
854	8,734	$55,845
855	337	$34,562
856	5,924	$76,601
857	9,805	$41,686
858	2,324	$32,633
862	9,495	$38,011
863	21,662	$24,948
864	18,165	$22,959
865	2,268	$32,370
866	7,434	$20,691
867	5,312	$44,169
868	2,854	$28,484
869	778	$18,946

MS-DRG	Number of Cases	Threshold
870	25,704	$106,185
871	246,469	$39,940
872	110,301	$29,921
876	656	$47,281
880	8,141	$17,733
881	4,536	$13,825
882	1,797	$13,928
883	863	$21,336
884	18,103	$22,036
885	88,143	$17,427
886	525	$16,974
887	466	$20,752
894	4,519	$9,250
895	6,272	$18,826
896	6,916	$31,320
897	36,847	$15,672
901	937	$59,770
902	1,889	$36,330
903	1,026	$27,622
904	1,894	$50,605
905	763	$30,023
906	706	$27,779
907	8,651	$64,343
908	9,015	$41,044
909	4,756	$30,985
913	871	$31,045
914	5,457	$19,215
915	1,429	$32,069
916	5,627	$12,701
917	19,110	$33,847
918	36,704	$17,074
919	10,760	$34,206
920	15,239	$25,970
921	7,309	$16,831
922	1,046	$31,696
923	3,197	$18,119
927	188	$191,332
928	947	$70,439
929	366	$39,682
933	138	$35,364
934	608	$27,112

MS-DRG	Number of Cases	Threshold
935	2,111	$25,585
939	718	$53,737
940	1,636	$38,331
941	1,454	$31,143
945	5,962	$22,482
946	2,808	$19,520
947	12,288	$28,163
948	55,407	$18,688
949	639	$24,011
950	276	$12,574
951	1,027	$17,059
955	443	$101,419
956	4,421	$63,509
957	1,436	$116,430
958	1,214	$76,277
959	200	$50,235
963	1,769	$55,015
964	2,904	$35,973
965	911	$25,761
969	631	$88,018
970	102	$55,798
974	5,213	$46,839
975	4,509	$31,862
976	1,528	$24,990
977	3,545	$27,392
981	25,552	$87,682
982	19,654	$58,273
983	4,889	$41,091
984	505	$63,106
985	1,056	$46,172
986	447	$30,153
987	7,984	$61,556
988	10,936	$41,576
989	3,945	$29,355
999	17	$24,638

[1]Cases taken from the FY 2009 MedPAR file; MS-DRGs are from GROUPER Version 28.0.

TABLE 11.—PROPOSED MS-LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011 UNDER THE LTCH PPS

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
1	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	0	0.0000	0.0	0.0
2	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	0	0.0000	0.0	0.0
3	3	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	270	4.6420	65.4	54.5
4	4	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	1,536	2.9398	43.7	36.4
5	5	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	0	0.0000	0.0	0.0
6	5	LIVER TRANSPLANT W/O MCC	0	0.0000	0.0	0.0
7	7	LUNG TRANSPLANT	0	0.0000	0.0	0.0
8	8	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0	0.0000	0.0	0.0
10	10	PANCREAS TRANSPLANT	0	0.0000	0.0	0.0
11	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	1	1.0834	28.9	24.1
12	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	0	0.8745	23.3	19.4
13	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	0	0.4878	18.1	15.1
14	14	ALLOGENEIC BONE MARROW TRANSPLANT	0	0.5578	19.4	16.2
15	15	AUTOLOGOUS BONE MARROW TRANSPLANT	0	0.5578	19.4	16.2
20	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	1	1.6495	36.4	30.3
21	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	0	0.6040	22.1	18.4
22	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	0	0.4878	18.1	15.1
23	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	0	1.0834	28.9	24.1
24	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	0	0.4878	18.1	15.1
25	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	2	1.0834	28.9	24.1
26	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	1	0.4878	18.1	15.1
27	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
28	28	SPINAL PROCEDURES W MCC	11	1.0834	28.9	24.1
29	28	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	16	0.8667	24.6	20.5

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
30	28	SPINAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
31	31	VENTRICULAR SHUNT PROCEDURES W MCC	1	1.0834	28.9	24.1
32	31	VENTRICULAR SHUNT PROCEDURES W CC	0	1.0834	28.9	24.1
33	31	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
34	34	CAROTID ARTERY STENT PROCEDURE W MCC	0	1.6495	36.4	30.3
35	34	CAROTID ARTERY STENT PROCEDURE W CC	0	1.6495	36.4	30.3
36	34	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	0	1.6495	36.4	30.3
37	37	EXTRACRANIAL PROCEDURES W MCC*	13	1.6495	36.4	30.3
38	37	EXTRACRANIAL PROCEDURES W CC	4	1.6495	36.4	30.3
39	37	EXTRACRANIAL PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
40	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	116	1.2680	34.0	28.3
41	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	82	0.8898	29.0	24.2
42	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	3	0.4878	18.1	15.1
52	52	SPINAL DISORDERS & INJURIES W CC/MCC*	64	1.1123	41.2	34.3
53	52	SPINAL DISORDERS & INJURIES W/O CC/MCC	6	1.1123	41.2	34.3
54	54	NERVOUS SYSTEM NEOPLASMS W MCC	32	0.7988	27.3	22.8
55	54	NERVOUS SYSTEM NEOPLASMS W/O MCC	35	0.5857	19.2	16.0
56	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1,122	0.8046	25.6	21.3
57	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1,142	0.5744	23.7	19.8
58	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	11	1.6495	36.4	30.3
59	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	14	0.6280	20.9	17.4
60	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	4	0.4878	18.1	15.1
61	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	0	0.9204	23.3	19.4
62	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	0	0.6172	22.1	18.4
63	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	0	0.6172	22.1	18.4
64	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	145	0.8377	24.2	20.2
65	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	52	0.6040	22.1	18.4
66	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	9	0.4878	18.1	15.1
67	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	0	0.4878	18.1	15.1
68	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	3	0.4878	18.1	15.1
69	69	TRANSIENT ISCHEMIA	2	1.0834	28.9	24.1
70	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	182	0.9204	23.3	19.4
71	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC*	92	0.6172	22.1	18.4
72	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	9	0.6172	22.1	18.4
73	73	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	112	0.8684	24.9	20.8
74	73	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	111	0.6375	21.9	18.3
75	75	VIRAL MENINGITIS W CC/MCC	9	0.8667	24.6	20.5
76	75	VIRAL MENINGITIS W/O CC/MCC	0	0.8667	24.6	20.5
77	77	HYPERTENSIVE ENCEPHALOPATHY W MCC	2	0.8667	24.6	20.5
78	77	HYPERTENSIVE ENCEPHALOPATHY W CC	2	0.8667	24.6	20.5
79	77	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0	0.6280	20.9	17.4
80	80	NONTRAUMATIC STUPOR & COMA W MCC	8	1.0834	28.9	24.1
81	80	NONTRAUMATIC STUPOR & COMA W/O MCC	6	0.4878	18.1	15.1
82	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	15	0.8667	24.6	20.5
83	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	9	0.6280	20.9	17.4
84	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	1	0.4878	18.1	15.1
85	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	92	0.9280	25.1	20.9
86	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	56	0.6865	23.9	19.9
87	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	8	0.4878	18.1	15.1
88	88	CONCUSSION W MCC	0	1.0834	28.9	24.1
89	88	CONCUSSION W CC	1	1.0834	28.9	24.1
90	88	CONCUSSION W/O CC/MCC	1	0.8667	24.6	20.5
91	91	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	264	0.8775	24.3	20.3
92	91	OTHER DISORDERS OF NERVOUS SYSTEM W CC	98	0.7482	24.2	20.2
93	91	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	7	0.4878	18.1	15.1
94	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	247	1.1110	29.4	24.5
95	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC*	99	0.8203	25.3	21.1
96	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	22	0.8203	25.3	21.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
97	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	70	0.9186	24.6	20.5
98	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	23	0.6280	20.9	17.4
99	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	4	0.4878	18.1	15.1
100	100	SEIZURES W MCC	32	0.7248	21.5	17.9
101	100	SEIZURES W/O MCC	36	0.6180	21.8	18.2
102	102	HEADACHES W MCC	2	0.8667	24.6	20.5
103	102	HEADACHES W/O MCC	0	0.4878	18.1	15.1
113	113	ORBITAL PROCEDURES W CC/MCC	1	1.0834	28.9	24.1
114	113	ORBITAL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
115	115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	0	1.0834	28.9	24.1
116	116	INTRAOCULAR PROCEDURES W CC/MCC	0	1.0834	28.9	24.1
117	116	INTRAOCULAR PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
121	121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	9	0.6280	20.9	17.4
122	121	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	3	0.4878	18.1	15.1
123	123	NEUROLOGICAL EYE DISORDERS	0	1.0834	28.9	24.1
124	124	OTHER DISORDERS OF THE EYE W MCC*	6	1.0834	28.9	24.1
125	124	OTHER DISORDERS OF THE EYE W/O MCC	3	1.0834	28.9	24.1
129	129	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	0	1.2634	27.1	22.6
130	129	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
131	131	CRANIAL/FACIAL PROCEDURES W CC/MCC	1	1.6495	36.4	30.3
132	131	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	0	0.8203	25.3	21.1
133	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	9	1.6495	36.4	30.3
134	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
135	135	SINUS & MASTOID PROCEDURES W CC/MCC	0	1.6495	36.4	30.3
136	135	SINUS & MASTOID PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
137	137	MOUTH PROCEDURES W CC/MCC	0	0.6280	20.9	17.4
138	137	MOUTH PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
139	139	SALIVARY GLAND PROCEDURES	0	0.6280	20.9	17.4
146	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	39	1.2634	27.1	22.6
147	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	31	0.8745	23.3	19.4
148	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	3	0.4878	18.1	15.1
149	149	DYSEQUILIBRIUM	2	0.4878	18.1	15.1
150	150	EPISTAXIS W MCC	0	0.8587	25.4	21.2
151	150	EPISTAXIS W/O MCC	1	0.4878	18.1	15.1
152	152	OTITIS MEDIA & URI W MCC	31	0.8587	25.4	21.2
153	152	OTITIS MEDIA & URI W/O MCC	28	0.5982	19.9	16.6
154	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	49	1.0726	26.3	21.9
155	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC*	42	0.8203	25.3	21.1
156	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	8	0.8203	25.3	21.1
157	157	DENTAL & ORAL DISEASES W MCC	9	1.0834	28.9	24.1
158	157	DENTAL & ORAL DISEASES W CC	24	0.6280	20.9	17.4
159	157	DENTAL & ORAL DISEASES W/O CC/MCC	4	0.6280	20.9	17.4
163	163	MAJOR CHEST PROCEDURES W MCC	28	2.4302	42.0	35.0
164	163	MAJOR CHEST PROCEDURES W CC	5	1.6495	36.4	30.3
165	163	MAJOR CHEST PROCEDURES W/O CC/MCC	0	1.5463	31.4	26.2
166	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	1,742	2.5489	42.0	35.0
167	166	OTHER RESP SYSTEM O.R. PROCEDURES W CC*	174	1.5463	31.4	26.2
168	166	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	8	1.5463	31.4	26.2
175	175	PULMONARY EMBOLISM W MCC	105	0.7521	22.7	18.9
176	175	PULMONARY EMBOLISM W/O MCC	72	0.5489	18.8	15.7
177	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	4,071	0.8895	22.9	19.1
178	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1,912	0.7193	20.8	17.3
179	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	143	0.6009	17.1	14.3
180	180	RESPIRATORY NEOPLASMS W MCC	117	0.7510	20.1	16.8
181	180	RESPIRATORY NEOPLASMS W CC	64	0.6640	19.9	16.6
182	180	RESPIRATORY NEOPLASMS W/O CC/MCC	2	0.6280	20.9	17.4
183	183	MAJOR CHEST TRAUMA W MCC	0	2.4302	42.0	35.0
184	183	MAJOR CHEST TRAUMA W CC	0	1.6495	36.4	30.3
185	183	MAJOR CHEST TRAUMA W/O CC/MCC	0	1.5463	31.4	26.2
186	186	PLEURAL EFFUSION W MCC	147	0.7405	20.7	17.3
187	186	PLEURAL EFFUSION W CC	41	0.5699	18.8	15.7
188	186	PLEURAL EFFUSION W/O CC/MCC	3	0.4878	18.1	15.1
189	189	PULMONARY EDEMA & RESPIRATORY FAILURE	8,376	0.9737	23.5	19.6
190	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	2,365	0.7421	20.2	16.8
191	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	1,129	0.6316	18.4	15.3
192	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	286	0.5081	16.4	13.7
193	193	SIMPLE PNEUMONIA & PLEURISY W MCC	2,120	0.7644	20.9	17.4
194	193	SIMPLE PNEUMONIA & PLEURISY W CC	1,554	0.6152	18.9	15.8
195	193	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	162	0.4881	16.7	13.9

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
196	196	INTERSTITIAL LUNG DISEASE W MCC	96	0.7048	20.4	17.0
197	196	INTERSTITIAL LUNG DISEASE W CC	71	0.6056	18.6	15.5
198	196	INTERSTITIAL LUNG DISEASE W/O CC/MCC	20	0.4878	18.1	15.1
199	199	PNEUMOTHORAX W MCC	80	0.7749	21.5	17.9
200	199	PNEUMOTHORAX W CC	15	0.6280	20.9	17.4
201	199	PNEUMOTHORAX W/O CC/MCC	4	0.4878	18.1	15.1
202	202	BRONCHITIS & ASTHMA W CC/MCC	114	0.7236	20.9	17.4
203	202	BRONCHITIS & ASTHMA W/O CC/MCC	10	0.6280	20.9	17.4
204	204	RESPIRATORY SIGNS & SYMPTOMS	144	0.7769	21.1	17.6
205	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	376	0.8291	22.1	18.4
206	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	145	0.7030	20.7	17.3
207	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	14,744	2.0241	33.3	27.8
208	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	1,828	1.0948	22.2	18.5
215	215	OTHER HEART ASSIST SYSTEM IMPLANT	0	0.6280	20.9	17.4
216	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	0	1.6495	36.4	30.3
217	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	0	1.2501	30.4	25.3
218	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	0	0.6280	20.9	17.4
219	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	0	1.6495	36.4	30.3
220	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	1	1.6495	36.4	30.3
221	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	0	0.6280	20.9	17.4
222	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	0	1.6495	36.4	30.3
223	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	0	0.8667	24.6	20.5
224	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	0	1.6495	36.4	30.3
225	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	1	0.6280	20.9	17.4
226	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6	1.6495	36.4	30.3
227	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	2	1.6495	36.4	30.3
228	228	OTHER CARDIOTHORACIC PROCEDURES W MCC	0	1.3830	30.1	25.1
229	228	OTHER CARDIOTHORACIC PROCEDURES W CC	0	1.2501	30.4	25.3
230	228	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
231	231	CORONARY BYPASS W PTCA W MCC	0	1.6495	36.4	30.3
232	231	CORONARY BYPASS W PTCA W/O MCC	0	0.6280	20.9	17.4
233	233	CORONARY BYPASS W CARDIAC CATH W MCC	0	1.6495	36.4	30.3
234	233	CORONARY BYPASS W CARDIAC CATH W/O MCC	0	0.6280	20.9	17.4
235	235	CORONARY BYPASS W/O CARDIAC CATH W MCC	0	1.6495	36.4	30.3
236	235	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	1	0.6280	20.9	17.4
237	237	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	6	1.6495	36.4	30.3
238	237	MAJOR CARDIOVASC PROCEDURES W/O MCC	0	0.6280	20.9	17.4
239	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	142	1.5508	36.9	30.8
240	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	55	1.3458	35.0	29.2
241	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	0	0.6280	20.9	17.4
242	242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3	1.6495	36.4	30.3
243	242	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	6	0.8667	24.6	20.5
244	242	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	1	0.4878	18.1	15.1
245	245	AICD GENERATOR PROCEDURES	0	0.4878	18.1	15.1
246	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	0	1.3830	30.1	25.1
247	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2	0.8667	24.6	20.5
248	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	1	1.6495	36.4	30.3
249	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1	0.6280	20.9	17.4
250	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	3	1.0834	28.9	24.1
251	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	0	1.0834	28.9	24.1
252	252	OTHER VASCULAR PROCEDURES W MCC	110	1.3830	30.1	25.1
253	252	OTHER VASCULAR PROCEDURES W CC	46	1.2501	30.4	25.3
254	252	OTHER VASCULAR PROCEDURES W/O CC/MCC	2	0.6280	20.9	17.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
255	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	37	1.2192	33.9	28.3
256	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	22	1.0834	28.9	24.1
257	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0	0.6280	20.9	17.4
258	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	1	0.8667	24.6	20.5
259	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	0	0.6280	20.9	17.4
260	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	2	1.6495	36.4	30.3
261	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	3	1.0834	28.9	24.1
262	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1	0.6280	20.9	17.4
263	263	VEIN LIGATION & STRIPPING	2	1.6495	36.4	30.3
264	264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	594	1.0441	30.6	25.5
265	265	AICD LEAD PROCEDURES	0	1.0441	30.6	25.5
280	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	271	0.7702	22.2	18.5
281	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	105	0.6663	20.9	17.4
282	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	12	0.4878	18.1	15.1
283	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	46	0.9091	17.2	14.3
284	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	6	0.6280	20.9	17.4
285	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0	0.6280	20.9	17.4
286	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	11	1.6495	36.4	30.3
287	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	5	0.8667	24.6	20.5
288	288	ACUTE & SUBACUTE ENDOCARDITIS W MCC	646	1.0263	26.3	21.9
289	288	ACUTE & SUBACUTE ENDOCARDITIS W CC	240	0.8452	26.2	21.8
290	288	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	25	0.7600	27.8	23.2
291	291	HEART FAILURE & SHOCK W MCC	1,436	0.7773	21.5	17.9
292	291	HEART FAILURE & SHOCK W CC	872	0.6120	19.5	16.3
293	291	HEART FAILURE & SHOCK W/O CC/MCC	83	0.4418	16.9	14.1
294	294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	8	1.6495	36.4	30.3
295	294	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0	0.5156	20.0	16.7
296	296	CARDIAC ARREST, UNEXPLAINED W MCC	0	0.7773	21.5	17.9
297	296	CARDIAC ARREST, UNEXPLAINED W CC	0	0.6120	19.5	16.3
298	296	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0	0.4418	16.9	14.1
299	299	PERIPHERAL VASCULAR DISORDERS W MCC	735	0.7976	23.7	19.8
300	299	PERIPHERAL VASCULAR DISORDERS W CC	696	0.5845	21.6	18.0
301	299	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	39	0.5156	20.0	16.7
302	302	ATHEROSCLEROSIS W MCC	49	0.8801	22.6	18.8
303	302	ATHEROSCLEROSIS W/O MCC	38	0.5651	21.5	17.9
304	304	HYPERTENSION W MCC	3	1.6495	36.4	30.3
305	304	HYPERTENSION W/O MCC	14	0.6280	20.9	17.4
306	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	58	0.8633	24.3	20.3
307	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	37	0.8144	24.4	20.3
308	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	131	0.7120	20.7	17.3
309	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	55	0.5307	19.3	16.1
310	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	11	0.4878	18.1	15.1
311	311	ANGINA PECTORIS	1	0.8667	24.6	20.5
312	312	SYNCOPE & COLLAPSE	29	0.4995	17.3	14.4
313	313	CHEST PAIN	3	0.8667	24.6	20.5
314	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1,566	0.9068	23.1	19.3
315	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	314	0.6812	21.5	17.9
316	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	26	0.5394	19.2	16.0
326	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	24	1.6495	36.4	30.3
327	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	3	0.8667	24.6	20.5
328	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1	0.8667	24.6	20.5
329	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	28	1.7888	41.2	34.3
330	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	8	1.6495	36.4	30.3
331	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
332	332	RECTAL RESECTION W MCC	0	1.0834	28.9	24.1
333	332	RECTAL RESECTION W CC	0	0.8667	24.6	20.5
334	332	RECTAL RESECTION W/O CC/MCC	0	0.8667	24.6	20.5
335	335	PERITONEAL ADHESIOLYSIS W MCC	10	1.6495	36.4	30.3
336	335	PERITONEAL ADHESIOLYSIS W CC	1	1.0834	28.9	24.1
337	335	PERITONEAL ADHESIOLYSIS W/O CC/MCC	0	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
338	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	0	0.7254	22.0	18.3
339	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	0	0.7254	22.0	18.3
340	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5065	17.1	14.3
341	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	0	0.9536	24.3	20.3
342	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	0	0.7254	22.0	18.3
343	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5065	17.1	14.3
344	344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC*	1	1.0834	28.9	24.1
345	344	MINOR SMALL & LARGE BOWEL PROCEDURES W CC*	1	1.0834	28.9	24.1
346	344	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
347	347	ANAL & STOMAL PROCEDURES W MCC	3	1.0834	28.9	24.1
348	347	ANAL & STOMAL PROCEDURES W CC	2	0.8667	24.6	20.5
349	347	ANAL & STOMAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
350	350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	1	1.6495	36.4	30.3
351	350	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	0	0.4878	18.1	15.1
352	350	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
353	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	3	1.0834	28.9	24.1
354	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1	0.4878	18.1	15.1
355	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	0	0.4878	18.1	15.1
356	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	141	1.7106	35.6	29.7
357	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	26	1.1300	29.0	24.2
358	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	3	1.0834	28.9	24.1
368	368	MAJOR ESOPHAGEAL DISORDERS W MCC	34	1.0400	22.4	18.7
369	368	MAJOR ESOPHAGEAL DISORDERS W CC	12	0.6280	20.9	17.4
370	368	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC*	1	0.6280	20.9	17.4
371	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	949	0.9536	24.3	20.3
372	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	342	0.7254	22.0	18.3
373	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	31	0.5065	17.1	14.3
374	374	DIGESTIVE MALIGNANCY W MCC	101	0.8268	21.0	17.5
375	374	DIGESTIVE MALIGNANCY W CC	56	0.6770	21.3	17.8
376	374	DIGESTIVE MALIGNANCY W/O CC/MCC	3	0.4878	18.1	15.1
377	377	G.I. HEMORRHAGE W MCC	88	0.7978	22.5	18.8
378	377	G.I. HEMORRHAGE W CC	43	0.6163	21.3	17.8
379	377	G.I. HEMORRHAGE W/O CC/MCC	8	0.4878	18.1	15.1
380	380	COMPLICATED PEPTIC ULCER W MCC	22	1.0834	28.9	24.1
381	380	COMPLICATED PEPTIC ULCER W CC	17	0.8667	24.6	20.5
382	380	COMPLICATED PEPTIC ULCER W/O CC/MCC	1	0.8667	24.6	20.5
383	383	UNCOMPLICATED PEPTIC ULCER W MCC	9	0.4878	18.1	15.1
384	383	UNCOMPLICATED PEPTIC ULCER W/O MCC*	5	0.4878	18.1	15.1
385	385	INFLAMMATORY BOWEL DISEASE W MCC	32	0.9126	23.3	19.4
386	385	INFLAMMATORY BOWEL DISEASE W CC	26	0.7394	25.5	21.3
387	385	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	2	0.4878	18.1	15.1
388	388	G.I. OBSTRUCTION W MCC	218	0.9443	23.4	19.5
389	388	G.I. OBSTRUCTION W CC	83	0.6325	19.8	16.5
390	388	G.I. OBSTRUCTION W/O CC/MCC	10	0.4878	18.1	15.1
391	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	342	0.9298	23.1	19.3
392	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	194	0.6310	19.9	16.6
393	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	970	1.0710	25.8	21.5
394	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	389	0.7560	21.8	18.2
395	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	17	0.6280	20.9	17.4
405	405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	17	1.6495	36.4	30.3
406	405	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2	1.0834	28.9	24.1
407	405	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
408	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	1	1.6495	36.4	30.3
409	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	1	1.0834	28.9	24.1
410	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	0	0.6280	20.9	17.4
411	411	CHOLECYSTECTOMY W C.D.E. W MCC	1	1.6495	36.4	30.3
412	411	CHOLECYSTECTOMY W C.D.E. W CC	0	1.6495	36.4	30.3
413	411	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	0	0.6280	20.9	17.4
414	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	0	1.6495	36.4	30.3
415	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0	1.6495	36.4	30.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
416	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1	1.6495	36.4	30.3
417	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	10	1.6495	36.4	30.3
418	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	2	1.6495	36.4	30.3
419	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1	0.6280	20.9	17.4
420	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	0	1.6495	36.4	30.3
421	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	0	1.6495	36.4	30.3
422	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
423	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	17	1.6495	36.4	30.3
424	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	3	1.6495	36.4	30.3
425	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
432	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	80	0.6674	20.3	16.9
433	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	11	0.6280	20.9	17.4
434	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0	0.6280	20.9	17.4
435	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	41	0.8842	20.1	16.8
436	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	11	0.6280	20.9	17.4
437	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	1	0.4878	18.1	15.1
438	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	310	1.0513	23.8	19.8
439	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	122	0.7550	21.1	17.6
440	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	13	0.4878	18.1	15.1
441	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	228	0.8011	22.2	18.5
442	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC*	72	0.7091	23.1	19.3
443	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	8	0.7091	23.1	19.3
444	444	DISORDERS OF THE BILIARY TRACT W MCC	127	0.7728	21.5	17.9
445	444	DISORDERS OF THE BILIARY TRACT W CC*	47	0.5847	20.7	17.3
446	444	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	12	0.5847	20.7	17.3
453	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	0	1.6495	36.4	30.3
454	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	0	1.6495	36.4	30.3
455	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	0	1.0834	28.9	24.1
456	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	2	1.6495	36.4	30.3
457	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	0	1.6495	36.4	30.3
458	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	0	1.0834	28.9	24.1
459	459	SPINAL FUSION EXCEPT CERVICAL W MCC	2	1.6495	36.4	30.3
460	459	SPINAL FUSION EXCEPT CERVICAL W/O MCC	1	1.0834	28.9	24.1
461	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	0	1.6495	36.4	30.3
462	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	0	1.6495	36.4	30.3
463	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	845	1.4194	39.1	32.6
464	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	306	1.0953	34.3	28.6
465	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	23	0.8667	24.6	20.5
466	466	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4	1.6495	36.4	30.3
467	466	REVISION OF HIP OR KNEE REPLACEMENT W CC	1	0.8667	24.6	20.5
468	466	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC*	0	0.8667	24.6	20.5
469	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	2	1.6495	36.4	30.3
470	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2	1.6495	36.4	30.3
471	471	CERVICAL SPINAL FUSION W MCC	0	1.0834	28.9	24.1
472	471	CERVICAL SPINAL FUSION W CC	1	1.0834	28.9	24.1
473	471	CERVICAL SPINAL FUSION W/O CC/MCC	0	1.0834	28.9	24.1
474	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	140	1.3860	36.9	30.8
475	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	51	1.0993	34.1	28.4
476	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	4	0.6280	20.9	17.4
477	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	32	1.3916	38.2	31.8
478	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	13	1.0834	28.9	24.1
479	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC*	1	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
480	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC*	13	1.6495	36.4	30.3
481	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	6	1.6495	36.4	30.3
482	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1	1.6495	36.4	30.3
483	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	0	1.6495	36.4	30.3
484	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	0	1.6495	36.4	30.3
485	485	KNEE PROCEDURES W PDX OF INFECTION W MCC	11	1.0834	28.9	24.1
486	485	KNEE PROCEDURES W PDX OF INFECTION W CC	9	1.0834	28.9	24.1
487	485	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	2	0.6280	20.9	17.4
488	488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	0	1.0834	28.9	24.1
489	488	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	0	0.6280	20.9	17.4
490	490	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	9	1.0834	28.9	24.1
491	490	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	2	0.4878	18.1	15.1
492	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	11	1.6495	36.4	30.3
493	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	17	1.6495	36.4	30.3
494	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1	0.8667	24.6	20.5
495	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	81	1.4624	37.6	31.3
496	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	22	1.0834	28.9	24.1
497	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1	1.0834	28.9	24.1
498	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	18	1.6495	36.4	30.3
499	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1	0.8667	24.6	20.5
500	500	SOFT TISSUE PROCEDURES W MCC	129	1.3544	36.4	30.3
501	500	SOFT TISSUE PROCEDURES W CC	38	0.9664	30.7	25.6
502	500	SOFT TISSUE PROCEDURES W/O CC/MCC	5	0.6280	20.9	17.4
503	503	FOOT PROCEDURES W MCC*	33	1.0106	31.5	26.3
504	503	FOOT PROCEDURES W CC	22	1.0106	31.5	26.3
505	503	FOOT PROCEDURES W/O CC/MCC	2	1.0106	31.5	26.3
506	506	MAJOR THUMB OR JOINT PROCEDURES	1	0.8667	24.6	20.5
507	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	2	1.6495	36.4	30.3
508	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
509	509	ARTHROSCOPY	2	1.6495	36.4	30.3
510	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	0	1.3468	31.7	26.4
511	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	0	0.8667	24.6	20.5
512	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	0	0.8667	24.6	20.5
513	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	8	1.0834	28.9	24.1
514	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0	0.8667	24.6	20.5
515	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	83	1.3468	31.7	26.4
516	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	23	0.8667	24.6	20.5
517	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC*	5	0.8667	24.6	20.5
533	533	FRACTURES OF FEMUR W MCC	3	1.0834	28.9	24.1
534	533	FRACTURES OF FEMUR W/O MCC	1	1.0834	28.9	24.1
535	535	FRACTURES OF HIP & PELVIS W MCC	26	0.7420	25.4	21.2
536	535	FRACTURES OF HIP & PELVIS W/O MCC	13	0.6280	20.9	17.4
537	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	1	0.4878	18.1	15.1
538	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0	0.4878	18.1	15.1
539	539	OSTEOMYELITIS W MCC	1,932	1.0093	30.7	25.6
540	539	OSTEOMYELITIS W CC	962	0.7936	27.5	22.9
541	539	OSTEOMYELITIS W/O CC/MCC	148	0.6821	24.4	20.3
542	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	37	0.9292	21.9	18.3
543	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	25	0.6938	22.1	18.4
544	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	4	0.6280	20.9	17.4
545	545	CONNECTIVE TISSUE DISORDERS W MCC	61	0.8812	21.8	18.2
546	545	CONNECTIVE TISSUE DISORDERS W CC	47	0.7162	24.1	20.1
547	545	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	2	0.4878	18.1	15.1
548	548	SEPTIC ARTHRITIS W MCC	260	0.9215	27.2	22.7
549	548	SEPTIC ARTHRITIS W CC	214	0.7472	26.6	22.2
550	548	SEPTIC ARTHRITIS W/O CC/MCC	39	0.5739	25.1	20.9
551	551	MEDICAL BACK PROBLEMS W MCC	130	0.9177	26.4	22.0
552	551	MEDICAL BACK PROBLEMS W/O MCC	116	0.5946	21.7	18.1
553	553	BONE DISEASES & ARTHROPATHIES W MCC	6	0.4878	18.1	15.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
554	553	BONE DISEASES & ARTHROPATHIES W/O MCC*	17	0.4878	18.1	15.1
555	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC*	15	0.6280	20.9	17.4
556	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	12	0.6280	20.9	17.4
557	557	TENDONITIS, MYOSITIS & BURSITIS W MCC	114	0.8794	26.1	21.8
558	557	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	109	0.6295	21.9	18.3
559	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1,722	0.8472	25.6	21.3
560	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1,411	0.6950	24.9	20.8
561	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	243	0.5788	23.0	19.2
562	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	13	0.8667	24.6	20.5
563	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	14	0.8667	24.6	20.5
564	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	384	0.8675	23.5	19.6
565	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	207	0.6727	22.6	18.8
566	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	25	0.5464	19.5	16.3
573	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	1,862	1.3702	38.2	31.8
574	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1,163	1.0312	34.5	28.8
575	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	77	0.7628	28.0	23.3
576	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	44	1.4531	38.4	32.0
577	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	26	0.9545	30.8	25.7
578	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	3	0.4878	18.1	15.1
579	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	626	1.3095	35.4	29.5
580	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	315	0.9380	31.5	26.3
581	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	12	0.8667	24.6	20.5
582	582	MASTECTOMY FOR MALIGNANCY W CC/MCC	0	1.6495	36.4	30.3
583	582	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0	0.5998	20.1	16.8
584	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	4	0.6280	20.9	17.4
585	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	0	0.6016	22.3	18.6
592	592	SKIN ULCERS W MCC	3,450	0.9187	26.5	22.1
593	592	SKIN ULCERS W CC	2,181	0.6858	25.1	20.9
594	592	SKIN ULCERS W/O CC/MCC	151	0.5644	23.1	19.3
595	595	MAJOR SKIN DISORDERS W MCC	48	0.9095	24.7	20.6
596	595	MAJOR SKIN DISORDERS W/O MCC	33	0.5998	20.1	16.8
597	597	MALIGNANT BREAST DISORDERS W MCC	15	1.6495	36.4	30.3
598	597	MALIGNANT BREAST DISORDERS W CC	11	0.6280	20.9	17.4
599	597	MALIGNANT BREAST DISORDERS W/O CC/MCC	0	0.4878	18.1	15.1
600	600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	29	0.6625	24.0	20.0
601	600	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	5	0.4878	18.1	15.1
602	602	CELLULITIS W MCC	1,133	0.7276	22.1	18.4
603	602	CELLULITIS W/O MCC	1,519	0.5291	19.1	15.9
604	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	37	0.6494	23.4	19.5
605	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	50	0.6016	22.3	18.6
606	606	MINOR SKIN DISORDERS W MCC	94	0.8380	22.8	19.0
607	606	MINOR SKIN DISORDERS W/O MCC	98	0.5684	20.2	16.8
614	614	ADRENAL & PITUITARY PROCEDURES W CC/MCC	0	0.9743	28.6	23.8
615	614	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
616	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	104	1.5785	39.7	33.1
617	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	115	1.0153	31.1	25.9
618	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	0	1.0153	31.1	25.9
619	619	O.R. PROCEDURES FOR OBESITY W MCC	3	1.0834	28.9	24.1
620	619	O.R. PROCEDURES FOR OBESITY W CC	0	1.0834	28.9	24.1
621	619	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	0	1.0834	28.9	24.1
622	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	261	1.2544	35.9	29.9
623	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	352	0.9977	30.8	25.7
624	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	9	0.6280	20.9	17.4
625	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	1	0.6280	20.9	17.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
626	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC*	0	0.6280	20.9	17.4
627	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC*	0	0.6280	20.9	17.4
628	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	68	1.2313	32.7	27.3
629	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	108	0.9743	28.6	23.8
630	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	3	0.8667	24.6	20.5
637	637	DIABETES W MCC	687	0.8949	26.2	21.8
638	637	DIABETES W CC	1,035	0.7071	23.4	19.5
639	637	DIABETES W/O CC/MCC	32	0.4679	20.0	16.7
640	640	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	678	0.8741	23.1	19.3
641	640	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	465	0.6222	20.6	17.2
642	642	INBORN ERRORS OF METABOLISM	5	1.0834	28.9	24.1
643	643	ENDOCRINE DISORDERS W MCC	17	0.6280	20.9	17.4
644	643	ENDOCRINE DISORDERS W CC	18	0.6280	20.9	17.4
645	643	ENDOCRINE DISORDERS W/O CC/MCC	4	0.4878	18.1	15.1
652	652	KIDNEY TRANSPLANT	0	0.0000	0.0	0.0
653	653	MAJOR BLADDER PROCEDURES W MCC	1	1.6495	36.4	30.3
654	653	MAJOR BLADDER PROCEDURES W CC	0	1.0834	28.9	24.1
655	653	MAJOR BLADDER PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
656	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	1	0.4878	18.1	15.1
657	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	0	0.4878	18.1	15.1
658	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	0	0.4878	18.1	15.1
659	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC*	4	1.0834	28.9	24.1
660	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	4	1.0834	28.9	24.1
661	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	0	1.0834	28.9	24.1
662	662	MINOR BLADDER PROCEDURES W MCC	0	1.0834	28.9	24.1
663	662	MINOR BLADDER PROCEDURES W CC	1	1.0834	28.9	24.1
664	662	MINOR BLADDER PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
665	665	PROSTATECTOMY W MCC	2	1.0834	28.9	24.1
666	665	PROSTATECTOMY W CC	0	1.0834	28.9	24.1
667	665	PROSTATECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
668	668	TRANSURETHRAL PROCEDURES W MCC	9	1.0834	28.9	24.1
669	668	TRANSURETHRAL PROCEDURES W CC	1	0.6280	20.9	17.4
670	668	TRANSURETHRAL PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
671	671	URETHRAL PROCEDURES W CC/MCC	3	0.8667	24.6	20.5
672	671	URETHRAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
673	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	212	1.3836	32.9	27.4
674	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	44	0.9783	27.9	23.3
675	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	3	0.8667	24.6	20.5
682	682	RENAL FAILURE W MCC	1,584	0.9085	23.1	19.3
683	682	RENAL FAILURE W CC	538	0.6892	21.0	17.5
684	682	RENAL FAILURE W/O CC/MCC	28	0.6199	17.1	14.3
685	685	ADMIT FOR RENAL DIALYSIS	1	1.0834	28.9	24.1
686	686	KIDNEY & URINARY TRACT NEOPLASMS W MCC	15	0.8667	24.6	20.5
687	686	KIDNEY & URINARY TRACT NEOPLASMS W CC	14	0.6280	20.9	17.4
688	686	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0	0.6280	20.9	17.4
689	689	KIDNEY & URINARY TRACT INFECTIONS W MCC	942	0.6715	21.7	18.1
690	689	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	682	0.5198	19.3	16.1
691	691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	0	0.8667	24.6	20.5
692	691	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	0	0.4878	18.1	15.1
693	693	URINARY STONES W/O ESW LITHOTRIPSY W MCC	11	0.8667	24.6	20.5
694	693	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	1	0.4878	18.1	15.1
695	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	5	0.8667	24.6	20.5
696	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	4	0.4878	18.1	15.1
697	697	URETHRAL STRICTURE	1	0.8667	24.6	20.5
698	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	345	0.8846	22.9	19.1
699	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	134	0.6313	20.2	16.8
700	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	11	0.6280	20.9	17.4
707	707	MAJOR MALE PELVIC PROCEDURES W CC/MCC	0	1.0834	28.9	24.1
708	707	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
709	709	PENIS PROCEDURES W CC/MCC	5	1.0834	28.9	24.1
710	709	PENIS PROCEDURES W/O CC/MCC	1	0.6280	20.9	17.4
711	711	TESTES PROCEDURES W CC/MCC	5	1.0834	28.9	24.1
712	711	TESTES PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
713	713	TRANSURETHRAL PROSTATECTOMY W CC/MCC	4	0.8667	24.6	20.5
714	713	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0	0.6280	20.9	17.4
715	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	0	1.6495	36.4	30.3
716	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0	1.0834	28.9	24.1
717	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	11	1.6495	36.4	30.3
718	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1	1.0834	28.9	24.1
722	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	8	1.0834	28.9	24.1
723	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	9	0.6280	20.9	17.4
724	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0	0.6280	20.9	17.4
725	725	BENIGN PROSTATIC HYPERTROPHY W MCC	2	1.6495	36.4	30.3
726	725	BENIGN PROSTATIC HYPERTROPHY W/O MCC	1	0.8667	24.6	20.5
727	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	75	0.8106	22.6	18.8
728	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	57	0.5026	17.3	14.4
729	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	68	0.8981	26.5	22.1
730	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	3	0.4878	18.1	15.1
734	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	0	1.0834	28.9	24.1
735	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
736	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	0	1.0834	28.9	24.1
737	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	0	0.6280	20.9	17.4
738	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	0	0.6280	20.9	17.4
739	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	0	1.2313	32.7	27.3
740	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC*	0	0.9743	28.6	23.8
741	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	0	0.8667	24.6	20.5
742	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC*	0	0.9743	28.6	23.8
743	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0	0.8667	24.6	20.5
744	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	0	1.0834	28.9	24.1
745	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0	1.0834	28.9	24.1
746	746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	4	1.0834	28.9	24.1
747	746	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
748	748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0	1.0834	28.9	24.1
749	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	7	1.0834	28.9	24.1
750	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
754	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	17	1.0834	28.9	24.1
755	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	11	0.6280	20.9	17.4
756	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC*	0	0.6279	20.9	17.4
757	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	72	0.7744	24.6	20.5
758	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	40	0.6839	23.9	19.9
759	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	7	0.4878	18.1	15.1
760	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC*	4	0.8667	24.6	20.5
761	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC*	2	0.8667	24.6	20.5
765	765	CESAREAN SECTION W CC/MCC	0	1.0834	28.9	24.1
766	765	CESAREAN SECTION W/O CC/MCC	0	1.0834	28.9	24.1
767	767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0	1.0834	28.9	24.1
768	768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0	1.0834	28.9	24.1
769	769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2	1.6495	36.4	30.3
770	770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0	1.0834	28.9	24.1
774	774	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0	1.0834	28.9	24.1
775	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0	1.0834	28.9	24.1

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776	776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1	0.6280	20.9	17.4
777	777	ECTOPIC PREGNANCY	0	0.6280	20.9	17.4
778	778	THREATENED ABORTION	0	0.6280	20.9	17.4
779	779	ABORTION W/O D&C	0	0.6280	20.9	17.4
780	780	FALSE LABOR	0	0.6280	20.9	17.4
781	781	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	3	0.4878	18.1	15.1
782	782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0	0.4878	18.1	15.1
789	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0	0.4878	18.1	15.1
790	790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0	0.4878	18.1	15.1
791	791	PREMATURITY W MAJOR PROBLEMS	0	0.4878	18.1	15.1
792	792	PREMATURITY W/O MAJOR PROBLEMS	0	0.4878	18.1	15.1
793	793	FULL TERM NEONATE W MAJOR PROBLEMS	0	0.4878	18.1	15.1
794	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	0	0.4878	18.1	15.1
795	795	NORMAL NEWBORN	0	0.4878	18.1	15.1
799	799	SPLENECTOMY W MCC	0	1.0834	28.9	24.1
800	799	SPLENECTOMY W CC	0	1.0834	28.9	24.1
801	799	SPLENECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
802	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	1	1.0834	28.9	24.1
803	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	0	1.0834	28.9	24.1
804	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	0	1.0834	28.9	24.1
808	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	12	0.8667	24.6	20.5
809	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	14	0.6280	20.9	17.4
810	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0	0.5578	19.4	16.2
811	811	RED BLOOD CELL DISORDERS W MCC	65	0.8441	21.1	17.6
812	811	RED BLOOD CELL DISORDERS W/O MCC	38	0.5578	19.4	16.2
813	813	COAGULATION DISORDERS	35	0.7443	20.8	17.3
814	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	29	0.8803	24.8	20.7
815	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	14	0.6280	20.9	17.4
816	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0	0.6280	20.9	17.4
820	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	0	0.4878	18.1	15.1
821	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	1	0.4878	18.1	15.1
822	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	0	0.4878	18.1	15.1
823	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	3	1.6495	36.4	30.3
824	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1	0.4878	18.1	15.1
825	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	0	0.4878	18.1	15.1
826	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	0	0.8667	24.6	20.5
827	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	1	0.8667	24.6	20.5
828	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	0	0.8667	24.6	20.5
829	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	7	1.6495	36.4	30.3
830	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	0	1.6495	36.4	30.3
834	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	22	0.8667	24.6	20.5
835	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	12	0.8667	24.6	20.5
836	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1	0.6280	20.9	17.4
837	837	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	0	1.3820	29.1	24.3
838	837	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	0	1.3026	28.6	23.8
839	837	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	0	1.3026	28.6	23.8
840	840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	91	0.8901	22.1	18.4
841	840	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	38	0.6737	18.8	15.7
842	840	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	4	0.4878	18.1	15.1
843	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	7	0.8667	24.6	20.5
844	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	7	0.8667	24.6	20.5
845	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	1	0.4878	18.1	15.1
846	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	57	1.3820	29.1	24.3
847	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	54	1.3026	28.6	23.8
848	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0	1.3026	28.6	23.8
849	849	RADIOTHERAPY	119	0.7730	22.7	18.9

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853	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	1,059	1.7413	37.6	31.3
854	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	96	1.1085	30.2	25.2
855	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	2	0.8667	24.6	20.5
856	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	361	1.4571	34.1	28.4
857	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	194	1.0415	30.5	25.4
858	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	10	0.8667	24.6	20.5
862	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1,722	0.9661	25.3	21.1
863	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1,019	0.6984	23.0	19.2
864	864	FEVER	3	0.4878	18.1	15.1
865	865	VIRAL ILLNESS W MCC	26	0.8013	21.3	17.8
866	865	VIRAL ILLNESS W/O MCC*	13	0.8013	21.3	17.8
867	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	450	1.0443	23.7	19.8
868	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	64	0.6882	19.5	16.3
869	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	2	0.4878	18.1	15.1
870	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	1,282	2.1404	31.7	26.4
871	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	5,885	0.8725	23.1	19.3
872	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,275	0.6255	20.3	16.9
876	876	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3	1.6495	36.4	30.3
880	880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	9	0.6280	20.9	17.4
881	881	DEPRESSIVE NEUROSES	34	0.3912	21.9	18.3
882	882	NEUROSES EXCEPT DEPRESSIVE	10	0.4878	18.1	15.1
883	883	DISORDERS OF PERSONALITY & IMPULSE CONTROL	7	0.6280	20.9	17.4
884	884	ORGANIC DISTURBANCES & MENTAL RETARDATION	76	0.5153	25.7	21.4
885	885	PSYCHOSES	877	0.3977	24.2	20.2
886	886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	38	0.4205	24.7	20.6
887	887	OTHER MENTAL DISORDER DIAGNOSES	2	0.4878	18.1	15.1
894	894	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0	0.4878	18.1	15.1
895	895	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0	0.4878	18.1	15.1
896	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	12	0.8667	24.6	20.5
897	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	8	0.4878	18.1	15.1
901	901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	292	1.3896	34.4	28.7
902	901	WOUND DEBRIDEMENTS FOR INJURIES W CC	138	1.0410	29.9	24.9
903	901	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	6	0.6280	20.9	17.4
904	904	SKIN GRAFTS FOR INJURIES W CC/MCC	100	1.3723	38.3	31.9
905	904	SKIN GRAFTS FOR INJURIES W/O CC/MCC	2	0.8667	24.6	20.5
906	906	HAND PROCEDURES FOR INJURIES	3	0.6280	20.9	17.4
907	907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	135	1.4580	34.3	28.6
908	907	OTHER O.R. PROCEDURES FOR INJURIES W CC	57	0.9544	28.7	23.9
909	907	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	4	0.6280	20.9	17.4
913	913	TRAUMATIC INJURY W MCC	49	0.7653	24.3	20.3
914	913	TRAUMATIC INJURY W/O MCC	79	0.5687	20.1	16.8
915	915	ALLERGIC REACTIONS W MCC	1	0.4878	18.1	15.1
916	915	ALLERGIC REACTIONS W/O MCC	0	0.4878	18.1	15.1
917	917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	8	1.0834	28.9	24.1
918	917	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	3	0.4878	18.1	15.1
919	919	COMPLICATIONS OF TREATMENT W MCC	1,547	1.0957	26.7	22.3
920	919	COMPLICATIONS OF TREATMENT W CC	888	0.8190	24.9	20.8
921	919	COMPLICATIONS OF TREATMENT W/O CC/MCC	53	0.5150	18.4	15.3
922	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	7	0.8667	24.6	20.5
923	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	11	0.4878	18.1	15.1
927	927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	0	1.0834	28.9	24.1
928	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	11	1.0834	28.9	24.1
929	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	1	1.0834	28.9	24.1
933	933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	11	0.6280	20.9	17.4
934	934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	31	0.6455	23.9	19.9
935	935	NON-EXTENSIVE BURNS	64	0.6800	22.2	18.5
939	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	225	1.4032	33.6	28.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
940	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	98	1.0076	31.1	25.9
941	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	9	0.6280	20.9	17.4
945	945	REHABILITATION W CC/MCC	1,338	0.6482	21.1	17.6
946	945	REHABILITATION W/O CC/MCC	89	0.4068	17.2	14.3
947	947	SIGNS & SYMPTOMS W MCC	41	0.8225	23.5	19.6
948	947	SIGNS & SYMPTOMS W/O MCC	51	0.4846	19.9	16.6
949	949	AFTERCARE W CC/MCC	3,264	0.7151	22.1	18.4
950	949	AFTERCARE W/O CC/MCC	194	0.4499	17.1	14.3
951	951	OTHER FACTORS INFLUENCING HEALTH STATUS	66	1.5229	27.2	22.7
955	955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.0834	28.9	24.1
956	956	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.6495	36.4	30.3
957	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	1	0.6280	20.9	17.4
958	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC*	0	0.6280	20.9	17.4
959	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC*	0	0.6280	20.9	17.4
963	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC*	8	1.0834	28.9	24.1
964	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	8	1.0834	28.9	24.1
965	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1	0.4878	18.1	15.1
969	969	HIV W EXTENSIVE O.R. PROCEDURE W MCC	12	1.6495	36.4	30.3
970	969	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2	0.8667	24.6	20.5
974	974	HIV W MAJOR RELATED CONDITION W MCC	210	1.0512	23.2	19.3
975	974	HIV W MAJOR RELATED CONDITION W CC	58	0.6394	18.6	15.5
976	974	HIV W MAJOR RELATED CONDITION W/O CC/MCC	7	0.4878	18.1	15.1
977	977	HIV W OR W/O OTHER RELATED CONDITION	30	0.6746	19.9	16.6
981	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	1,045	2.1787	41.6	34.7
982	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	219	1.1314	30.7	25.6
983	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	6	0.6280	20.9	17.4
984	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	19	1.6495	36.4	30.3
985	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	8	1.0834	28.9	24.1
986	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	0	1.0834	28.9	24.1
987	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	467	1.8330	38.5	32.1
988	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	172	1.0342	30.2	25.2
989	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	4	0.6280	20.9	17.4
998	998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	0.0000	0.0	0.0
999	999	UNGROUPABLE	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529(a) in conjunction with §412.503).

* In determining the proposed MS-LTC-DRG relative weights for FY 2011, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section VIII.B.3.g. (step 6) of the preamble of this proposed rule.

TABLE 12A.—PROPOSED LTCH PPS WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
10180	Abilene, TX	
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	0.8016
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	0.3476
10420	Akron, OH	
	Portage County, OH	
	Summit County, OH	0.8857
10500	Albany, GA	
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	0.9050
10580	Albany-Schenectady-Troy, NY	
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	0.8667
10740	Albuquerque, NM	
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	0.9454
10780	Alexandria, LA	
	Grant Parish, LA	
	Rapides Parish, LA	0.8008
10900	Allentown-Bethlehem-Easton, PA-NJ	
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	0.9178
11020	Altoona, PA	
	Blair County, PA	0.8634
11100	Amarillo, TX	
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	0.8658
11180	Ames, IA	
	Story County, IA	0.9986
11260	Anchorage, AK	
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	1.1984
11300	Anderson, IN	
	Madison County, IN	0.9207
11340	Anderson, SC	
	Anderson County, SC	0.8969
11460	Ann Arbor, MI	
	Washtenaw County, MI	1.0140
11500	Anniston-Oxford, AL	
	Calhoun County, AL	0.7931
11540	Appleton, WI	
	Calumet County, WI	
	Outagamie County, WI	0.9376
11700	Asheville, NC	
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	0.9016
12020	Athens-Clarke County, GA	
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	0.9546

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA	
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	0.9566
12100	Atlantic City, NJ- Hammonton, New Jersey	
	Atlantic County, NJ	1.1147
12220	Auburn-Opelika, AL	
	Lee County, AL	0.7255
12260	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	0.9522

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12420	Austin-Round Rock-San Marcos, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	0.9529
12540	Bakersfield-Delano, CA	
	Kern County, CA	1.1655
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	1.0267
12620	Bangor, ME	
	Penobscot County, ME	0.9793
12700	Barnstable Town, MA	
	Barnstable County, MA	1.2844
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	0.8597
12980	Battle Creek, MI	
	Calhoun County, MI	0.9671
13020	Bay City, MI	
	Bay County, MI	0.9235
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	0.8502
13380	Bellingham, WA	
	Whatcom County, WA	1.1408
13460	Bend, OR	
	Deschutes County, OR	1.1388

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
13644	Bethesda- - Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0542
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8688
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8733
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	0.8616
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7360
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8328
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9004
14060	Bloomington-Normal, IL McLean County, IL	0.9455
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9288
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2215
14500	Boulder, CO Boulder County, CO	1.0081
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8680
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0684
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2567
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9188
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9224
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9545
15500	Burlington, NC Alamance County, NC	0.8878
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9963
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1268
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0403
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8761
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9191
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8905
16180	Carson City, NV Carson City, NV	1.0482
16220	Casper, WY Natrona County, WY	0.9670

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
16300	Cedar Rapids, IA	
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	0.8858
16580	Champaign-Urbana, IL	
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	1.0251
16620	Charleston, WV	
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	0.7908
16700	Charleston-North CharlestonSummerville, SC	
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	0.9345
16740	Charlotte-Gastonia-Rock Hill, NC-SC	
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	0.9435
16820	Charlottesville, VA	
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	0.9358
16860	Chattanooga, TN-GA	
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	0.8755
16940	Cheyenne, WY	
	Laramie County, WY	0.9408

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
16974	Chicago- Joliet-Naperville, 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	1.0573
17020	Chico, CA	
	Butte County, CA	1.1572
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	0.9714
17300	Clarksville, TN-KY	
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	0.7898
17420	Cleveland, TN	
	Bradley County, TN	
	Polk County, TN	0.7744
17460	Cleveland-Elyria-Mentor, OH	
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	0.9052
17660	Coeur d'Alene, ID	
	Kootenai County, ID	0.9379

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
17780	College Station-Bryan, TX	
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	0.9604
17820	Colorado Springs, CO	
	El Paso County, CO	
	Teller County, CO	0.9497
17860	Columbia, MO	
	Boone County, MO	
	Howard County, MO	0.8295
17900	Columbia, SC	
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	0.8721
17980	Columbus, GA-AL	
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	0.9042
18020	Columbus, IN	
	Bartholomew County, IN	0.9449
18140	Columbus, OH	
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	1.0157
18580	Corpus Christi, TX	
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	0.8599
18700	Corvallis, OR	
	Benton County, OR	1.0472
18880	Crestview-Fort Walton Beach- Destin, FL	
	Okaloosa County, FL	0.8856
19060	Cumberland, MD-WV	
	Allegany County, MD	
	Mineral County, WV	0.8199
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	0.9848
19140	Dalton, GA	
	Murray County, GA	
	Whitfield County, GA	0.8610
19180	Danville, IL	
	Vermilion County, IL	0.9708
19260	Danville, VA	
	Pittsylvania County, VA	
	Danville City, VA	0.8182
19340	Davenport-Moline-Rock Island, IA-IL	
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	0.8414
19380	Dayton, OH	
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	0.9155
19460	Decatur, AL	
	Lawrence County, AL	
	Morgan County, AL	0.7618
19500	Decatur, IL	
	Macon County, IL	0.7929
19660	Deltona-Daytona Beach-Ormond Beach, FL	
	Volusia County, FL	0.8750

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
19740	Denver-Aurora-Broomfield, CO	
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	1.0735
19780	Des Moines,-West Des Moines, IA	
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	0.9637
19804	Detroit-Livonia-Dearborn, MI	
	Wayne County, MI	0.9702
20020	Dothan, AL	
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	0.7635
20100	Dover, DE	
	Kent County, DE	0.9937
20220	Dubuque, IA	
	Dubuque County, IA	0.8788
20260	Duluth, MN-WI	
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	1.0469
20500	Durham-Chapel Hill, NC	
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	0.9680
20740	Eau Claire, WI	
	Chippewa County, WI	
	Eau Claire County, WI	0.9655

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
20764	Edison-New Brunswick, NJ	
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	1.1022
20940	El Centro, CA	
	Imperial County, CA	0.9273
21060	Elizabethtown, KY	
	Hardin County, KY	
	Larue County, KY	0.8463
21140	Elkhart-Goshen, IN	
	Elkhart County, IN	0.9480
21300	Elmira, NY	
	Chemung County, NY	0.8459
21340	El Paso, TX	
	El Paso County, TX	0.8489
21500	Erie, PA	
	Erie County, PA	0.8371
21660	Eugene-Springfield, OR	
	Lane County, OR	1.1402
21780	Evansville, IN-KY	
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	0.8446
21820	Fairbanks, AK	
	Fairbanks North Star Borough, AK	1.1098
21940	Fajardo, PR	
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	0.3889
	Fargo, ND-MN	
22020	Cass County, ND	
	Clay County, MN	0.8049
22140	Farmington, NM	
	San Juan County, NM	0.8000
22180	Fayetteville, NC	
	Cumberland County, NC	
	Hoke County, NC	0.9339

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8630
22380	Flagstaff, AZ Coconino County, AZ	1.2463
22420	Flint, MI Genesee County, MI	1.1515
22500	Florence, SC Darlington County, SC Florence County, SC	0.8264
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8058
22540	Fond du Lac, WI Fond du Lac County, WI	0.9238
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9908
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0170
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7601
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9322
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9490
23420	Fresno, CA Fresno County, CA	1.1439
23460	Gadsden, AL Etowah County, AL	0.7028
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9175
23580	Gainesville, GA Hall County, GA	0.9386
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9099
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8521
24140	Goldsboro, NC Wayne County, NC	0.9081
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7729
24300	Grand Junction, CO Mesa County, CO	0.9866
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9183
24500	Great Falls, MT Cascade County, MT	0.8303
24540	Greeley, CO Weld County, CO	0.9511
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9601
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8897
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9385

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
24860	Greenville-Mauldin-Easley, SC	
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	0.9563
25020	Guayama, PR	
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	0.3692
25060	Gulfport-Biloxi, MS	
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	0.8990
25180	Hagerstown-Martinsburg, MD-WV	
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	0.9269
25260	Hanford-Corcoran, CA	
	Kings County, CA	1.1223
25420	Harrisburg-Carlisle, PA	
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	0.9311
25500	Harrisonburg, VA	
	Rockingham County, VA	
	Harrisonburg City, VA	0.9173
25540	Hartford-West Hartford-East Hartford, CT	
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	1.0936
25620	Hattiesburg, MS	
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	0.7727
25860	Hickory-Lenoir-Morganton, NC	
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	0.8707
25980	Hinesville-Fort Stewart, GA	
	Liberty County, GA	
	Long County, GA	0.8955
26100	Holland-Grand Haven, MI	
	Ottawa County, MI	0.8646

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
26180	Honolulu, HI	
	Honolulu County, HI	1.1801
26300	Hot Springs, AR	
	Garland County, AR	0.9166
26380	Houma-Bayou Cane-Thibodaux, LA	
	Lafourche Parish, LA	
	Terrebonne Parish, LA	0.7865
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	0.8967
26620	Huntsville, AL	
	Limestone County, AL	
	Madison County, AL	0.9130
26820	Idaho Falls, ID	
	Bonneville County, ID	
	Jefferson County, ID	0.9678
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	0.9687

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
26980	Iowa City, IA	
	Johnson County, IA	
	Washington County, IA	0.9672
27060	Ithaca, NY	
	Tompkins County, NY	0.9858
27100	Jackson, MI	
	Jackson County, MI	0.9170
27140	Jackson, MS	
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	0.8105
27180	Jackson, TN	
	Chester County, TN	
	Madison County, TN	0.8418
27260	Jacksonville, FL	
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	0.8899
27340	Jacksonville, NC	
	Onslow County, NC	0.7819
27500	Janesville, WI	
	Rock County, WI	0.9430
27620	Jefferson City, MO	
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	0.8448
27740	Johnson City, TN	
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	0.7269
27780	Johnstown, PA	
	Cambria County, PA	0.8103
27860	Jonesboro, AR	
	Craighead County, AR	
	Poinsett County, AR	0.7770
27900	Joplin, MO	
	Jasper County, MO	
	Newton County, MO	0.8227

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
28020	Kalamazoo-Portage, MI	
	Kalamazoo County, MI	
	Van Buren County, MI	1.0309
28100	Kankakee-Bradley, IL	
	Kankakee County, IL	1.0636
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	0.9667
28420	Kennewick- Pasco-Richland, WA	
	Benton County, WA	
	Franklin County, WA	0.9992
28660	Killeen-Temple-Fort Hood, TX	
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	0.8711
28700	Kingsport-Bristol-Bristol, TN-VA	
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	0.7596
28740	Kingston, NY	
	Ulster County, NY	0.9089
28940	Knoxville, TN	
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	0.7856

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9134
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9819
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9304
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8499
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8209
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0799
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0252
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8461
29540	Lancaster, PA Lancaster County, PA	0.9359
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0315
29700	Laredo, TX Webb County, TX	0.7927
29740	Las Cruces, NM Dona Ana County, NM	0.9311
29820	Las Vegas-Paradise, NV Clark County, NV	1.2119
29940	Lawrence, KS Douglas County, KS	0.8547
30020	Lawton, OK Comanche County, OK	0.8298
30140	Lebanon, PA Lebanon County, PA	0.7820

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9373
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8917
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8832
30620	Lima, OH Allen County, OH	0.9285
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9633
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	0.8542
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8808
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8582
31020	Longview, WA Cowlitz County, WA	1.0313
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2054

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31140	Louisville-Jefferson County, KY-IN	
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	0.8898
31180	Lubbock, TX	
	Crosby County, TX	
	Lubbock County, TX	0.8862
31340	Lynchburg, VA	
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	0.8679
31420	Macon, GA	
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	0.9044
31460	Madera-Chowchilla, CA	
	Madera County, CA	0.7999
31540	Madison, WI	
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	1.1307
31700	Manchester-Nashua, NH	
	Hillsborough County, NH	0.9885
31740	Mahattan, KS	
	Geary County, KS	
	Pottawatomie County, KS	
	Riley County; KS	0.7860

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31860	Mankato-North Mankato, MN	
	Blue Earth County, MN	
	Nicollet County, MN	0.9098
31900	Mansfield, OH	
	Richland County, OH	0.8932
32420	Mayagüez, PR	
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	0.3646
32580	McAllen-Edinburg-Mission, TX	
	Hidalgo County, TX	0.8852
32780	Medford, OR	
	Jackson County, OR	1.0077
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	0.9205
32900	Merced, CA	
	Merced County, CA	1.2241
33124	Miami-Miami Beach-Kendall, FL	
	Miami-Dade County, FL	1.0144
33140	Michigan City-La Porte, IN	
	LaPorte County, IN	0.9485
33260	Midland, TX	
	Midland County, TX	0.9727
33340	Milwaukee-Waukesha-West Allis, WI	
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	1.0200

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
33460	Minneapolis-St. Paul-Bloomington, MN-WI	
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	1.1161
33540	Missoula, MT	
	Missoula County, MT	0.8935
33660	Mobile, AL	
	Mobile County, AL	0.7949
33700	Modesto, CA	
	Stanislaus County, CA	1.2123
33740	Monroe, LA	
	Ouachita Parish, LA	
	Union Parish, LA	0.8008
33780	Monroe, MI	
	Monroe County, MI	0.8698
33860	Montgomery, AL	
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	0.8346
34060	Morgantown, WV	
	Monongalia County, WV	
	Preston County, WV	0.8150
34100	Morristown, TN	
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	0.7046
34580	Mount Vernon-Anacortes, WA	
	Skagit County, WA	1.0379
34620	Muncie, IN	
	Delaware County, IN	0.8219
34740	Muskegon-Norton Shores, MI	
	Muskegon County, MI	0.9805

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
34820	Myrtle Beach- North Myrtle Beach-Conway, SC	
	Horry County, SC	0.8726
34900	Napa, CA	
	Napa County, CA	1.4628
34940	Naples-Marco Island, FL	
	Collier County, FL	0.9714
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	0.9390
35004	Nassau-Suffolk, NY	
	Nassau County, NY	
	Suffolk County, NY	1.2333
35084	Newark-Union, NJ-PA	
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	1.1461
35300	New Haven-Milford, CT	
	New Haven County, CT	1.1534
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	0.9085

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	1.2949
35660	Niles-Benton Harbor, MI	
	Berrien County, MI	0.8887
35840	North Port-Bradenton-Sarasota, FL	
	Manatee County, FL	
	Sarasota County, FL	0.9495
35980	Norwich-New London, CT	
	New London County, CT	1.1234
36084	Oakland-Fremont-Hayward, CA	
	Alameda County, CA	
	Contra Costa County, CA	1.6374
36100	Ocala, FL	
	Marion County, FL	0.8482
36140	Ocean City, NJ	
	Cape May County, NJ	1.0896
36220	Odessa, TX	
	Ector County, TX	0.9451
36260	Ogden-Clearfield, UT	
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	0.9282
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	0.8892
36500	Olympia, WA	
	Thurston County, WA	1.1287

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	0.9599
36740	Orlando-Kissimmee-Sanford, FL	
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	0.9159
36780	Oshkosh-Neenah, WI	
	Winnebago County, WI	0.9582
36980	Owensboro, KY	
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	0.8384
37100	Oxnard-Thousand Oaks-Ventura, CA	
	Ventura County, CA	1.2397
37340	Palm Bay-Melbourne-Titusville, FL	
	Brevard County, FL	0.9226
	Palm Coast, FL	
37380	Flager County, FL	0.8419
37460	Panama City-Lynn Haven-Panama City Beach, FL	
	Bay County, FL	0.7967
37620	Parkersburg-Marietta-Vienna, WV-OH	
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	0.7467
37700	Pascagoula, MS	
	George County, MS	
	Jackson County, MS	0.8312
	Peabody, MA	
37764	Essex County, MA	1.0996
37860	Pensacola-Ferry Pass-Brent, FL	
	Escambia County, FL	
	Santa Rosa County, FL	0.8267

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
37900	Peoria, IL	
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	0.9163
37964	Philadelphia, PA	
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	1.0818
38060	Phoenix-Mesa-Glendale, AZ	
	Maricopa County, AZ	
	Pinal County, AZ	1.0662
38220	Pine Bluff, AR	
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	0.8025
38300	Pittsburgh, PA	
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	0.8619
38340	Pittsfield, MA	
	Berkshire County, MA	1.0388
38540	Pocatello, ID	
	Bannock County, ID	
	Power County, ID	0.9523
38660	Ponce, PR	
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	0.4320
38860	Portland-South Portland-Biddeford, ME	
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	0.9905

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
38900	Portland-Vancouver-Hillsboro, OR-WA	
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	1.1495
38940	Port St. Lucie, FL	
	Martin County, FL	
	St. Lucie County, FL	1.0740
39100	Poughkeepsie-Newburgh-Middletown, NY	
	Dutchess County, NY	
	Orange County, NY	1.1350
39140	Prescott, AZ	
	Yavapai County, AZ	1.2253
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	1.0731
39340	Provo-Orem, UT	
	Juab County, UT	
	Utah County, UT	0.9336
39380	Pueblo, CO	
	Pueblo County, CO	0.8735
39460	Punta Gorda, FL	
	Charlotte County, FL	0.8773
39540	Racine, WI	
	Racine County, WI	1.0597
39580	Raleigh-Cary, NC	
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	0.9827
39660	Rapid City, SD	
	Meade County, SD	
	Pennington County, SD	1.0459
39740	Reading, PA	
	Berks County, PA	0.8918
39820	Redding, CA	
	Shasta County, CA	1.4146

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
39900	Reno-Sparks, NV	
	Storey County, NV	
	Washoe County, NV	1.0436
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	0.9677
40140	Riverside-San Bernardino-Ontario, CA	
	Riverside County, CA	
	San Bernardino County, CA	1.1553
40220	Roanoke, VA	
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	0.8841
40340	Rochester, MN	
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	1.0960
40380	Rochester, NY	
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	0.8609
40420	Rockford, IL	
	Boone County, IL	
	Winnebago County, IL	1.0049
40484	Rockingham County-Strafford County, NH	
	Rockingham County, NH	
	Strafford County, NH	1.0042
40580	Rocky Mount, NC	
	Edgecombe County, NC	
	Nash County, NC	0.9049
40660	Rome, GA	
	Floyd County, GA	0.8817
40900	Sacramento--Arden-Arcade--Roseville, CA	
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	1.3949
40980	Saginaw-Saginaw Township North, MI	
	Saginaw County, MI	0.8742
41060	St. Cloud, MN	
	Benton County, MN	
	Stearns County, MN	1.1060
41100	St. George, UT	
	Washington County, UT	0.9148
41140	St. Joseph, MO-KS	
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	1.0318

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	0.9105
41420	Salem, OR	
	Marion County, OR	
	Polk County, OR	1.1151
41500	Salinas, CA	
	Monterey County, CA	1.5711
41540	Salisbury, MD	
	Somerset County, MD	
	Wicomico County, MD	0.9020
41620	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	0.9281
41660	San Angelo, TX	
	Irion County, TX	
	Tom Green County, TX	0.8317
41700	San Antonio-New Braunfels, 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	0.9013

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41740	San Diego-Carlsbad-San Marcos, CA	
	San Diego County, CA	1.1858
41780	Sandusky, OH	
	Erie County, OH	0.8700
41884	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	1.5740
41900	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	0.4567
41940	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
	Santa Clara County, CA	1.6730

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR	
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	0.4303

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
42020	San Luis Obispo-Paso Robles, CA	
	San Luis Obispo County, CA	1.2927
42044	Santa Ana-Anaheim-Irvine, CA	
	Orange County, CA	1.2181
42060	Santa Barbara-Santa Maria-Goleta, CA	
	Santa Barbara County, CA	1.1986
42100	Santa Cruz-Watsonville, CA	
	Santa Cruz County, CA	1.6768
42140	Santa Fe, NM	
	Santa Fe County, NM	1.0864
42220	Santa Rosa-Petaluma, CA	
	Sonoma County, CA	1.6167
42340	Savannah, GA	
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	0.8918
42540	Scranton--Wilkes-Barre, PA	
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	0.8252
42644	Seattle-Tacoma-Bellevue, WA	
	King County, WA	
	Snohomish County, WA	1.1574
42680	Sebastian-Vero Beach, FL	
	Indian River County, FL	0.9111
43100	Sheboygan, WI	
	Sheboygan County, WI	0.9248
43300	Sherman-Denison, TX	
	Grayson County, TX	0.8292
43340	Shreveport-Bossier City, LA	
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	0.8550
43580	Sioux City, IA-NE-SD	
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	0.9106
43620	Sioux Falls, SD	
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	0.9314

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
43780	South Bend-Mishawaka, IN-MI	
	St. Joseph County, IN	
	Cass County, MI	0.9964
43900	Spartanburg, SC	
	Spartanburg County, SC	0.9268
44060	Spokane, WA	
	Spokane County, WA	1.0588
44100	Springfield, IL	
	Menard County, IL	
	Sangamon County, IL	0.9145
44140	Springfield, MA	
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	1.0236
44180	Springfield, MO	
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	0.8271
44220	Springfield, OH	
	Clark County, OH	0.9249
44300	State College, PA	
	Centre County, PA	0.8793
44600	SteubenvilleWeirton-, WV-OH	
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	0.7326
44700	Stockton, CA	
	San Joaquin County, CA	1.2576
44940	Sumter, SC	
	Sumter County, SC	0.7873
45060	Syracuse, NY	
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	0.9631
45104	Tacoma, WA	
	Pierce County, WA	1.1362
45220	Tallahassee, FL	
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	0.8820

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
45300	Tampa-St. Petersburg-Clearwater, FL	
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	0.9068
45460	Terre Haute, IN	
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	0.9220
45500	Texarkana, TX-Texarkana, AR	
	Miller County, AR	
	Bowie County, TX	0.7654
45780	Toledo, OH	
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	0.9447
45820	Topeka, KS	
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	0.8967
45940	Trenton-Ewing, NJ	
	Mercer County, NJ	1.0167
46060	Tucson, AZ	
	Pima County, AZ	0.9495
46140	Tulsa, OK	
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	0.8802
46220	Tuscaloosa, AL	
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	0.8003
46340	Tyler, TX	
	Smith County, TX	0.8078

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
46540	Utica-Rome, NY	
	Herkimer County, NY	
	Oneida County, NY	0.8485
46660	Valdosta, GA	
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	0.7937
46700	Vallejo-Fairfield, CA	
	Solano County, CA	1.4939
47020	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	0.8232
47220	Vineland-Millville-Bridgeton, NJ	
	Cumberland County, NJ	1.0432
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	0.8975
47300	Visalia-Porterville, CA	
	Tulare County, CA	1.0756
47380	Waco, TX	
	McLennan County, TX	0.8417
47580	Warner Robins, GA	
	Houston County, GA	0.7951
47644	Warren-Troy-Farmington Hills, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	0.9662
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	1.0722
47940	Waterloo-Cedar Falls, IA	
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	0.8476
48140	Wausau, WI	
	Marathon County, WI	0.9358
48300	Wenatchee- East Wenatchee, WA	
	Chelan County, WA	
	Douglas County, WA	0.9631
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	
	Palm Beach County, FL	0.9949
48540	Wheeling, WV-OH	
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	0.6686

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8913
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9581
48700	Williamsport, PA Lycoming County, PA	0.7267
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0597
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9150
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0018
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8953
49340	Worcester, MA Worcester County, MA	1.1030
49420	Yakima, WA Yakima County, WA	1.0083
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3542
49620	York-Hanover, PA York County, PA	0.9542
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8639
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1061
49740	Yuma, AZ Yuma County, AZ	0.9298

TABLE 12B.—PROPOSED LTCH PPS WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Nonurban Area	Proposed LTCH PPS Wage Index
01	Alabama	0.7376
02	Alaska	1.2646
03	Arizona	0.9094
04	Arkansas	0.7234
05	California	1.2456
06	Colorado	0.9949
07	Connecticut	1.1139
08	Delaware	0.9771
10	Florida	0.8422
11	Georgia	0.7567
12	Hawaii	1.1100
13	Idaho	0.7568
14	Illinois	0.8357
15	Indiana	0.8404
16	Iowa	0.8584
17	Kansas	0.7994
18	Kentucky	0.7827
19	Louisiana	0.7724
20	Maine	0.8602
21	Maryland	0.9189
22	Massachusetts	1.1788
23	Michigan	0.8569
24	Minnesota	0.9053
25	Mississippi	0.7647
26	Missouri	0.7648
27	Montana	0.8531
28	Nebraska	0.8920
29	Nevada	0.9365
30	New Hampshire	0.9894
31	New Jersey*	-------
32	New Mexico	0.8948
33	New York	0.8198
34	North Carolina	0.8379
35	North Dakota	0.6842
36	Ohio	0.8542
37	Oklahoma	0.7867
38	Oregon	1.0045
39	Pennsylvania	0.8482
41	Rhode Island*	-------
42	South Carolina	0.8431
43	South Dakota	0.8549
44	Tennessee	0.7879
45	Texas	0.7818
46	Utah	0.8663
47	Vermont	0.9606
49	Virginia	0.7853
50	Washington	1.0200
51	West Virginia	0.7484
52	Wisconsin	0.8976
53	Wyoming	0.9544

*All counties within the State are classified as urban.

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Appendix A: Regulatory Impact Analysis

Note: The impacts of the proposed FY 2011 policy changes and payment rates addressed in this Appendix do not reflect the provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152). A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2011 acute care hospital operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The proposed market basket update to the IPPS rates required by the statute, in conjunction with other proposed payment changes in this proposed rule, would result in an estimated $142 million decrease in FY 2011 operating payments (or −0.1 percent increase), and an estimated $20 million decrease in FY 2011 capital payments (or −0.2 percent change). The impact analysis of the capital payments can be found in section VIII. of this Appendix. In addition, as described in section IX. of this Appendix, LTCHs are expected to experience an increase in payments by $41 million (or 0.8 percent).

Our operating impact estimate includes the proposed −2.9 percent documentation and coding adjustment applied to the hospital-specific rates, the proposed −2.4 percent documentation and coding adjustment applied to the Puerto Rico-specific rates and the proposed −2.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts. In addition, our operating impact estimate includes the proposed 2.4 percent market basket update to the standardized amount. The estimates of IPPS operating payments to acute care hospitals do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the Table of Small Business Size Standards for NAIC 622 found on the Small Business Administration Office of Size Standards Web site at: *http://www.sba.gov/contractingopportunities/officials/size/GC-SMALL-BUS-SIZE-STANDARDS.html.)* For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that the provisions of this proposed rule relating to acute care hospitals would have a significant impact on small entities as explained in this Appendix. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we are assuming that all LTCHs are considered small entities for the purpose of the analysis in section IX. of this Appendix. Medicare fiscal intermediaries and MACs are not considered to be small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our proposed regulatory flexibility analysis. Therefore, we are soliciting public comments on our estimates and analysis of the impact of this proposed rule on those small entities.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28, requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this proposed rule are available on the CMS IPPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.* We also note that the Hospital Center Web page at *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table 1 and section VI. of this Appendix for the quantitative effects of the proposed policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This proposed rule would not mandate any requirements for State,

local, or tribal governments, nor would it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives of the IPPS

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the proposed changes in this proposed rule would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of the prospective payment systems are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2011, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that implementation of the MS–DRGs would lead to increases in case-mix that do not reflect actual increases in patients' severity of illness as a result of more comprehensive documentation and coding. As explained in section II.D. of the preamble of this proposed rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90. Section 7 of Public Law 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43773), we postponed the documentation and coding adjustment to the average standardized amount until FY 2011 and did not apply the adjustment to the average standardized amount for FY 2010. An analysis of the FY 2008 IPPS claims data and the FY 2009 IPPS claims data found that an estimated recoupment adjustment of −5.8 percent applied to the national standardized amount is required to remove the full effects of documentation and coding due to the transition to MS–DRGs. Therefore, we are proposing to reduce the national standardized amount for IPPS hospitals by 2.9 percent in FY 2011 with additional reductions in subsequent years.

Furthermore, we believe that hospitals that are paid under the hospital-specific payment rate, specifically SCHs and MDHs, experience similar increases in case-mix due to documentation and coding changes that do not reflect real changes in case-mix. Our actuarial office estimates that hospitals paid under the hospital-specific rate experienced a 4.8 percent increase in payments due to documentation and coding changes in FY 2008 and FY 2009. We did not apply a documentation and coding adjustment to the hospital-specific rates when we first implemented the MS–DRG system. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43776), we postponed the documentation and coding adjustment to the hospital-specific payment rate until FY 2011 and did not apply the adjustment to hospital-specific payment rate for FY 2010. We believe that SCHs and MDHs paid under the hospital-specific rate also should receive an adjustment to the hospital-specific rate due to changes in documentation and coding that do not reflect real changes in case-mix. Our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent to the hospital-specific payment rate would address the effect of the documentation and coding changes on future payments. Therefore, for FY 2011, we are proposing to apply a −2.9 percent documentation and coding adjustment to the hospital-specific payment rate.

Our analysis, as described in section II.D. of the preamble of this proposed rule, shows that Puerto Rico hospitals experienced an increase in case-mix by 1.1 percent in FY 2008 due to changes in documentation and coding. We did not apply a documentation and coding adjustment to the Puerto Rico-specific rate when we first implemented the MS–DRG system. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43777), consistent with our decision to postpone documentation and coding adjustments for the hospital-specific rate and the Federal standardized amount, we also postponed the documentation and coding adjustment to the Puerto Rico-specific payment rate. Analysis of claims data from Puerto Rico hospitals found that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Therefore, for FY 2011, we are proposing to apply a −2.4 percent adjustment to the Puerto Rico-specific rate to account for changes due to documentation and coding.

The impacts shown below illustrate the impact of the proposed FY 2011 IPPS changes on acute care hospital operating payments, including the proposed −2.9 percent FY 2011 documentation and coding adjustment to the IPPS national standardized amount, the proposed −2.9 percent FY 2011 documentation and coding adjustment to the hospital-specific payment rates, and the proposed −2.4 percent FY 2011 documentation and coding adjustment to the Puerto Rico-specific standardized amount. The proposed documentation and coding adjustment that would be applicable to the Federal rate under the LTCH PPS for FY 2011 is discussed in section IX. of this Appendix. As we have done in the previous rules, we are soliciting public comments and information about the anticipated effects of the proposed changes on acute care hospitals and our methodology for estimating them.

IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs of acute care hospitals encompass most general short-term,

acute care hospitals that participate in the Medicare program. There were 33 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS pursuant to the waiver under section 1814(b)(3) of the Act.

As of March 2010, there are 3,472 IPPS acute care hospitals to be included in our analysis. This represents about 64 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,338 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. (We refer readers to section VII. of this Appendix for a further description of the impact of CAH-related proposed policy changes.) There are also 1,270 IPPS-excluded hospitals and 2,169 IPPS-excluded hospital units. These IPPS-excluded hospitals and units include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these IPPS-excluded hospitals and units are not included in this proposed rule. The impact of the proposed update and policy changes to the LTCH PPS for FY 2011 are discussed in section IX. of this Appendix.

V. Effects on Hospitals and Hospital Units Excluded From the IPPS

As of March 2010, there were 3,439 hospitals and hospital units excluded from the IPPS. Of these, 78 children's hospitals, 11 cancer hospitals, and 17 RNHCIs are being paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 228 rehabilitation hospitals and 961 rehabilitation units, and 429 LTCHs, are paid the Federal prospective per discharge rate under the IRF PPS and the LTCH PPS, respectively, and 507 psychiatric hospitals and 1,208 psychiatric units are paid the Federal per diem amount under the IPF PPS. As stated above, IRFs and IPFs are not affected by rate updates in this proposed rule. The impacts of the changes to LTCHs are discussed in section IX. of this Appendix.

In the past, certain hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Cancer and children's hospitals continue to be paid on a reasonable cost basis subject to TEFRA limits for FY 2011. For these hospitals (cancer and children's hospitals), consistent with the authority provided in section 1886(b)(3)(B)(ii) of the Act, the update is the percentage increase in the FY 2011 IPPS operating market basket. In compliance with section 404 of the MMA, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43930), we replaced the FY 2002-based IPPS operating and capital market baskets with the revised and rebased FY 2006-based IPPS operating and capital market baskets. Therefore, consistent with current law, based on IHS Global Insight, Inc.'s 2010 first quarter forecast, with historical data through the 2009 fourth quarter, we are estimating that the proposed FY 2011 update to the IPPS operating market basket would be 2.4 percent (that is, the current estimate of the market basket rate-of-increase). In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40. Therefore, for RNHCIs, the proposed update is the same as for children's and cancer hospitals, which is the percentage increase in the FY 2011 IPPS operating market basket increase, estimated to be 2.4 percent.

The impact of the proposed update in the rate-of-increase limit on those excluded hospitals depends on the cumulative cost increases experienced by each excluded hospital since its applicable base period. For excluded hospitals that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these excluded hospitals receive. Conversely, for excluded hospitals with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital that continues to be paid under the TEFRA system, whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, cancer and children's hospitals can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing proposed policy changes and payment rate updates for the IPPS for operating costs of acute care hospitals. Updates to the capital payments to acute care hospitals are discussed in section VIII. of this Appendix. Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2011 operating payments would decrease by 0.1 percent compared to FY 2010, largely due to the documentation and coding adjustments and market basket update to the IPPS rates. This amount reflects the proposed FY 2011 documentation and coding adjustments described above and in section II.D. of the preamble of this proposed rule: −2.9 percent for the IPPS national standardized amounts, −2.9 percent for the IPPS hospital-specific rates, and −2.4 percent for the IPPS Puerto Rico-specific standardized amount. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system for acute care hospitals. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain proposed changes in this proposed rule. However, there are other proposed changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2009 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the proposed changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment

components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2009 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of the capital IPPS for FY 2011 are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effects of the proposed annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based MS–DRG relative weights.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2007, compared to the FY 2006 wage data.
- The effects of the recalibration of the MS–DRG relative weights as required by section 1886(d)(4)(C) of the Act, including the proposed wage and recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2011.
- The effects of the third year of the 3-year transition to apply rural floor budget neutrality adjustment at the State level. For purposes of this impact analysis, we assume that in FY 2011, hospitals will receive a wage index with the State level rural and imputed floor budget neutrality adjustment. However, we recognize that this policy was recently changed by the provisions of section 3141 of Public Law 111–148 and will address the new impact in a separate document in the **Federal Register**.
- The effects of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total estimated change in payments based on the proposed FY 2011 policies relative to payments based on FY 2010 policies that include the proposed market basket update of 2.4 percent.

To illustrate the impacts of the proposed FY 2011 changes, our analysis begins with a FY 2010 baseline simulation model using: The proposed FY 2011 market basket update of 2.4 percent; the FY 2010 MS–DRG GROUPER (Version 27.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2010 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating MS–DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of Public Law 109–171, provides that, for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data in a form and manner and at a time specified by the Secretary. At the time that this impact was prepared, 104 hospitals did not receive the full market basket rate-of-increase for FY 2010 because they failed the quality data submission process or did not choose to participate. For purposes of the simulations shown below, we modeled the proposed payment changes for FY 2011 using a reduced update for these 104 hospitals. However, we do not have enough information at this time to determine which hospitals will not receive the full market basket rate-of-increase for FY 2011.

Each policy change, statutory or otherwise, is then added incrementally to this baseline, finally arriving at an FY 2011 model incorporating all of the changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the proposed percent change in payments per case from FY 2010 to FY 2011. Three factors not discussed separately have significant impacts here. The first factor is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the standardized amounts for FY 2011 using the most recently forecasted hospital market basket increase for FY 2011 of 2.4 percent. (Hospitals that fail to comply with the quality data submission requirements to receive the full update will receive an update reduced by 2.0 percentage points from 2.4 percent to 0.4 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for SCHs and for MDHs are also equal to the market basket percentage increase, or 2.4 percent.

A second significant factor that affects the changes in hospitals' payments per case from FY 2010 to FY 2011 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2010 that are no longer reclassified in FY 2011. Conversely, payments may increase for hospitals not reclassified in FY 2010 that are reclassified in FY 2011.

A third significant factor is that we currently estimate that actual outlier payments during FY 2011 will be 5.1 percent of total MS–DRG payments. When the FY 2010 final rule was published, we projected FY 2010 outlier payments would be 5.1 percent of total MS–DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2010 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2010 payments per case to estimated FY 2011 payments per case (with outlier payments projected to equal 5.1 percent of total MS–DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the proposed changes for FY 2011. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,472 acute care hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,502 hospitals located in urban areas included in our analysis. Among these, there are 1,365 hospitals located in large urban areas (populations over 1 million), and 1,137 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 970 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2011 payment classifications, including any reclassifications under section

1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the numbers of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,555, 1,403, 1,152 and 917, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,434 nonteaching hospitals in our analysis, 798 teaching hospitals with fewer than 100 residents, and 240 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban or rural, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 183 RRCs, 340 SCHs, 187 MDHs, and 108 hospitals that are both SCHs and RRCs, and 13 hospitals that are both an MDH and an RRC.

The next series of groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2008 or FY 2007 Medicare cost reports.

The next two groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2011. The second grouping shows the MGCRB rural reclassifications.

The final category shows the impact of the proposed policy changes on the 19 cardiac hospitals in our analysis.

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TABLE I.--IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2011

	No. of Hospitals	Proposed FY 2011 Weights & MS-DRG Changes (1)	Application of Recalibration Budget Neutrality (2)	Proposed FY 2011 Wage Data (3)	Application of Wage Budget Neutrality (4)	Proposed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recalibration Budget Neutrality (5)	FY 2011 MGCRB Reclassifications (6)	Proposed Rural Floor Budget Neutrality and Within State Rural Floor Budget Neutrality (7)	Proposed FY 2011 Out-Migration Adjustment (8)	All Proposed FY 2011 Changes Prior to the CMI Adjustment (9)	All Proposed FY 2011 Changes w/CMI Adjustment (10)
All Hospitals	3,472	0.3	0	0	0	0	0	0	0	2.8	-0.1
By Geographic Location:											
Urban hospitals	2,502	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Large urban areas	1,365	0.2	-0.1	0	0.1	0	-0.3	-0.1	0	2.8	-0.1
Other urban areas	1,137	0.4	0.1	-0.1	-0.1	0	0	0.1	0	2.9	-0.1
Rural hospitals	970	0.3	0	0	0	0	1.6	-0.1	0.1	2.4	-0.5
Bed Size (Urban):											
0-99 beds	635	0.6	0.2	0	0	0.3	-0.5	0	0	2.9	0
100-199 beds	791	0.2	-0.1	0	0	0	0	0.1	0	2.7	-0.2
200-299 beds	461	0.3	0	0	0	0	-0.1	0	0	2.7	-0.2
300-499 beds	425	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
500 or more beds	190	0.3	0	-0.1	-0.1	0	-0.2	-0.1	0	3	0.1
Bed Size (Rural):											
0-49 beds	337	0.6	0.3	0.1	0.1	0.3	0.6	0	0.2	2.9	0
50-99 beds	366	0.3	0	0	0	0	0.6	0	0.1	2.1	-0.8
100-149 beds	164	0.3	0	0	0	0	2.1	-0.1	0.1	2.5	-0.4
150-199 beds	61	0.3	0	0	0	0.1	2.4	-0.1	0	2.6	-0.3
200 or more beds	42	0.2	-0.1	0	0.1	-0.1	2.3	0	0	2.1	-0.8
Urban by Region:											
New England	121	0.1	-0.2	-0.4	-0.4	-0.6	0.9	0	0	2	-0.9

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
Middle Atlantic	330	0.3	0	-0.3	-0.3	-0.3	0.2	0	0	2.3	-0.6
South Atlantic	383	0.1	-0.2	0	0	-0.2	-0.3	0	0	2.8	-0.1
East North Central	403	0.1	-0.1	0.2	0.2	0.1	-0.2	0	0	3	0.1
East South Central	155	0.4	0.2	-0.5	-0.6	-0.4	-0.2	0	0	2.5	-0.4
West North Central	166	0.5	0.2	-0.1	-0.1	0.1	-0.7	0	0	3	0.1
West South Central	342	0.5	0.2	0.2	0.2	0.4	-0.6	0	0	3.2	0.3
Mountain	162	0.3	0	0	0	0	-0.3	0	0	3	0
Pacific	390	0.6	0.2	0.4	0.4	0.5	-0.3	0	0	3.4	0.5
Puerto Rico	50	0.9	0.7	-0.3	-0.3	0.4	-0.8	0	0	3.1	0.3
Rural by Region:											
New England	24	0.2	-0.2	0	0	-0.2	0.5	0	0	1.2	-1.6
Middle Atlantic	70	-0.1	-0.4	0.4	0.4	0	1.4	-0.1	0	2.1	-0.8
South Atlantic	165	-0.2	-0.5	-0.3	-0.4	-0.9	2	0	0.1	1.8	-1
East North Central	120	0.3	0	-0.1	-0.1	-0.2	1.3	0	0	2.2	-0.7
East South Central	175	0.6	0.3	0.2	0.2	0.5	2.4	-0.1	0.2	2.7	-0.2
West North Central	100	0.7	0.4	0	0	0.4	0.5	0	0	2.8	-0.1
West South Central	214	0.7	0.5	0.3	0.4	0.8	1.9	0	0.1	3.4	0.4
Mountain	71	0.7	0.4	0	0	0.4	0.1	0	0	2.8	-0.1
Pacific	31	0	-0.4	0.3	0.3	-0.1	0.9	-0.3	0	1.4	-1.5
By Payment Classification:											
Urban hospitals	2,555	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Large urban areas	1,403	0.2	0	0	0.1	0	-0.3	-0.1	0	2.8	-0.1

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
Other urban areas	1,152	0.4	0.1	-0.1	-0.1	0	0	0.1	0	2.9	-0.1
Rural areas	917	0.3	0	0	0	0	1.4	0	0.1	2.3	-0.5
Teaching Status:											
Nonteaching	2,434	0.4	0	0.1	0.1	0.1	0.2	0	0	2.8	-0.1
Fewer than 100 residents	798	0.3	0	-0.1	-0.1	-0.1	-0.2	0	0	2.7	-0.2
100 or more residents	240	0.3	0	-0.1	-0.1	-0.1	-0.2	-0.1	0	2.9	0
Urban DSH:											
Non-DSH	834	0.5	0.1	0	0	0	0.1	0	0	2.9	0
100 or more beds	1,510	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Less than 100 beds	340	0.2	-0.1	0	0	0	-0.3	-0.1	0	2.4	-0.5
Rural DSH:											
SCH	407	0.3	0	0	0	0	0.2	0	0.1	2.3	-0.6
RRC	209	0.2	-0.1	0.1	0.1	0	2.3	-0.1	0	2.3	-0.6
100 or more beds	30	0.1	-0.2	-0.3	-0.3	-0.5	1.2	0	0.3	2.3	-0.6
Less than 100 beds	142	0.4	0.2	0	0.1	0.2	0.9	-0.1	0.5	2.2	-0.7
Urban teaching and DSH:											
Both teaching and DSH	806	0.3	0	-0.1	-0.1	-0.1	-0.3	0	0	2.8	-0.1
Teaching and no DSH	169	0.3	-0.1	-0.2	-0.2	-0.2	0.4	0	0	2.7	-0.2
No teaching and DSH	1,044	0.3	0	0.2	0.2	0.2	0	0.1	0	2.8	-0.1

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
No teaching and no DSH	536	0.6	0.2	0	0	0.2	-0.2	0	0	3.1	0.2
Special Hospital Types:											
RRC	183	0.4	0.1	0	0	0.2	2.9	-0.1	0	2.5	-0.4
SCH	340	0.3	0	0	0	0	0	0	0	2.3	-0.5
MDH	187	0.2	-0.1	0	0	-0.1	0.4	-0.1	0.2	2.3	-0.6
SCH and RRC	108	0.2	-0.2	-0.1	-0.1	-0.2	0.7	0	0	2.1	-0.8
MDH and RRC	13	0.4	0	0.2	0.2	0.2	0.2	0	0.1	2.2	-0.6
Type of Ownership:											
Voluntary	1978	0.3	0	0	0	0	0	0	0	2.7	-0.2
Proprietary	837	0.4	0.1	0.2	0.2	0.3	-0.1	0	0	3	0.1
Government	577	0.3	0	-0.1	-0.1	0	0.1	0.1	0	2.9	-0.1
Medicare Utilization as a Percent of Inpatient Days:											
0-25	353	0.2	-0.1	0	0	0	-0.4	-0.1	0	2.8	-0.1
25-50	1,593	0.3	0	0	0	0	-0.3	0	0	2.9	-0.1
50-65	1,202	0.3	0	0	-0.1	-0.1	0.6	0	0	2.6	-0.3
Over 65	237	0.4	0.2	-0.1	-0.2	0	0.6	0.1	0	2.7	-0.2
FY 2011 Reclassifications by the Medicare Geographic Classification Review Board:											

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
All Reclassified Hospitals	810	0.3	0	0.1	0.1	0	1.8	-0.1	0	2.8	-0.1
Non-Reclassified Hospitals	2,662	0.3	0	0	0	0	-0.6	0	0	2.8	-0.1
Urban Hospitals Reclassified	488	0.3	0	0.1	0.1	0	1.6	-0.2	0	2.9	-0.1
Urban Nonreclassified Hospitals, FY 2011:	1,985	0.3	0	0	0	0	-0.7	0.1	0	2.8	-0.1
All Rural Hospitals Reclassified FY 2011:	322	0.3	0	0.1	0.1	0.1	2.7	-0.1	0	2.6	-0.3
Rural Nonreclassified Hospitals FY 2011:	585	0.4	0	0	0	0.1	-0.3	0	0.2	2.2	-0.7
All Section 401 Reclassified Hospitals:	37	-0.1	-0.4	-0.1	-0.1	-0.5	-0.3	0	0	1.8	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	-0.2	-0.5	-0.2	-0.2	-0.6	2.9	-0.1	0	1.7	-1.2
Specialty Hospitals											
Cardiac specialty Hospitals	19	1.1	0.8	0.3	0.3	1.1	-0.8	0	0	3.7	0.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2009, and hospital cost report data are from reporting periods beginning in FY 2008 and FY 2007.

[2] This column displays the payment impact of the proposed changes to the Version 28 GROUPER and the recalibration of the MS-DRG weights based on FY 2009 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the application of the recalibration budget neutrality factor of 0.996856, in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4].This column displays the proposed payment impact of the update to wage index data using FY 2007 cost report data.

[5]This column displays the payment impact of the application of the wage budget neutrality factor in accordance with section 1886(d)(3)(E)(i) of the Act. This factor is calculated separately from the recalibration budget neutrality factor. The wage budget neutrality factor is1.000107.

[6] This column displays the combined payment impact of the proposed changes in Columns 2 through 5 and the proposed cumulative budget neutrality factor for MS-DRG and wage changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act. The cumulative wage and recalibration budget neutrality factor of 0.996963is the product of the wage budget neutrality factor and the recalibration budget neutrality factor.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2011 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2011. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991756.

[8] This column displays the effects of the rural floor and the imputed floor, including the transition to the rural floor budget neutrality adjustment at the State level. Under the transition, hospitals will receive a blended wage index that is 100 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment.

[9] This column displays the impact of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows the proposed changes in payments from FY 2010 to FY 2011. It reflects the impact of the proposed FY 2011 market basket update, and the proposed reductions to the FY 2011 standardized amount due to the documentation and coding effect. The proposed FY 2011 documentation and coding adjustment is -2.9 percent to the IPPS standardized amounts, -2.9 percent to the hospital-specific rates, and -2.4 percent to the Puerto Rico-specific amount. It also reflects changes in hospitals' reclassification status in FY 2011 compared to FY 2010. It incorporates all of the proposed changes displayed in Columns 5, 6, 7, and 8 (the changes displayed in Columns 2, 4 are included in Column 5). The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

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C. Effects of the Proposed Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 1)

In Column 1 of Table I, we present the effects of the proposed MS–DRG reclassifications, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this proposed rule, the proposed FY 2011 MS–DRG relative weights will be 100 percent cost-based and 100 percent MS–DRGs. For FY 2011, the MS–DRGs are calculated using the FY 2009 MedPAR data grouped to the Version 28.0 (FY 2011) MS–DRGs. The methods of calculating the proposed relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this proposed rule. The proposed changes to the relative weights and MS–DRGs shown in Column 2 are prior to any offset for budget neutrality. Overall, hospitals will experience a 0.3 percent increase in payments due to the changes in the MS–DRGs and relative weights prior to budget neutrality. Urban hospitals and rural hospitals will experience a 0.3 percent increase in payments under the updates to the relative weights and MS–DRGs.

D. Effects of the Application of Recalibration Budget Neutrality (Column 2)

Column 2 shows the effects of the changes to the MS–DRGs and relative weights with the application of the recalibration budget neutrality factor to the standardized amounts. Consistent with section 1886(d)(4)(C)(iii) of the Act, we are calculating a recalibration budget neutrality factor to account for the changes in MS–DRGs and relative weights to ensure that the overall payment impact is budget neutral. In FY 2010, we began calculating a budget neutrality factor to account for changes in MS–DRGs and relative weights separately from the budget neutrality factor to account for changes in wage data. In addition, as described in section II.A.4. of the Addendum to this proposed rule, we are including IME payments made on Medicare Advantage claims to IPPS hospitals in order to calculate budget neutrality.

The "All Hospitals" line in Column 1 indicates that proposed changes due to MS–DRGs and relative weights will increase payments by 0.3 percent before application of the budget neutrality factor. The proposed recalibration budget neutrality factor is 0.996856, which is applied to the standardized amount. Thus, the impact after accounting only for budget neutrality for changes to the MS–DRG relative weights and classification is somewhat lower than the figures shown in Column 1 (approximately 0.3 percent). Consequentially, urban and rural hospitals will not experience a change in payments when recalibration budget neutrality is applied.

E. Effects of Proposed Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for acute care hospitals for FY 2011 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2006 and before October 1, 2007. The estimated impact of the updated wage data and labor share on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage change in payments when going from a model using the FY 2010 wage index, based on FY 2006 wage data, the current labor-related share and having a 100-percent occupational mix adjustment applied, to a model using the FY 2011 pre-reclassification wage index with the labor-related share, also having a 100-percent occupational mix adjustment applied, based on FY 2007 wage data (while holding other payment parameters such as use of the Version 28.0 MS–DRG GROUPER constant). The occupational mix adjustment is based on the FY 2008/2009 occupational mix survey.

Column 3 shows the impacts of updating the wage data using FY 2007 cost reports. Overall, the new wage data will lead to a 0.0 percent change for all hospitals before being combined with the wage budget neutrality adjustment shown in Column 5. Among the regions, the largest increase is in the rural Middle Atlantic region, which experiences a 0.4 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in Urban East South Central (0.5 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 1.2 percent compared to FY 2010. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 1.2 percent increase in average hourly wage. Of the 3,442 hospitals with wage data for both FYs 2010 and 2011, 2,696, or 78.3 percent, experienced an average hourly wage increase of 1.2 percent or more.

The following chart compares the shifts in proposed wage index values for hospitals for FY 2011 relative to FY 2010. Among urban hospitals, 39 will experience an increase of more than 5 percent and less than 10 percent and 7 will experience an increase of more than 10 percent. Among rural hospitals, 2 will experience an increase of more than 5 percent and less than 10 percent, and none will experience an increase of more than 10 percent. However, 938 rural hospitals will experience increases or decreases of less than 5 percent, while 2,415 urban hospitals will experience increases or decreases of less than 5 percent. Twenty-four urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Sixteen urban hospitals will experience decreases in their wage index values of greater than 10 percent. One rural hospital will experience a decrease of more than 10 percent. These figures reflect changes in the wage index which is an adjustment to either 68.8 percent or 62 percent of a hospital's standardized amount, depending upon whether its wage index is greater than 1.0 or less than or equal to 1.0. Therefore, these figures are illustrating a somewhat larger change in the wage index than will occur to the hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	7	0
Increase more than 5 percent and less than 10 percent	39	2
Increase or decrease less than 5 percent	2,415	938

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Decrease more than 5 percent and less than 10 percent	24	0
Decrease more than 10 percent	16	1

F. Application of the Wage Budget Neutrality Factor (Column 4)

Column 4 shows the impact of the new wage data with the application of the wage budget neutrality factor. In FY 2010, we began calculating separate wage budget neutrality and recalibration budget neutrality factors, in accordance with section 1886(d)(3)(E) of the Act, which specifies that budget neutrality to account for wage changes or updates made under that subparagraph must be made without regard to the 62 percent labor-related share guaranteed under section 1886(d)(3)(E)(ii) of the Act. Therefore, for FY 2011, we are calculating the wage budget neutrality factor to ensure that payments under updated wage data and the proposed labor-related share are budget neutral without regard to the lower labor-related share of 62 percent applied to hospitals with a wage index less than or equal to 1. In other words, the wage budget neutrality is calculated under the assumption that all hospitals receive the higher labor-related share of the standardized amount. Because the wage data changes did not change overall payments (displayed in Column 3), the wage budget neutrality factor is minimal at 1.000107, and the overall payment change is 0.0 percent.

G. Combined Effects of Proposed MS–DRG and Wage Index Changes (Column 5)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. We computed a proposed wage budget neutrality factor of 1.000107, and a proposed recalibration budget neutrality factor of 0.996856 (which is applied to the Puerto Rico specific standardized amount and the hospital-specific rates). The product of the two budget neutrality factors is the cumulative wage and recalibration budget neutrality factor. The proposed cumulative wage and recalibration budget neutrality adjustment is 0.996963, or approximately −0.3 percent, which is applied to the national standardized amounts. Because the wage budget neutrality and the recalibration budget neutrality are calculated under different methodologies according to the statute, when the two budget neutralities are combined and applied to the standardized amount, the overall payment impact is not necessarily budget neutral. However, in this proposed rule, we are estimating that the proposed changes in the MS–DRG, relative weights and updated wage data with wage and budget neutrality applied will result in a 0.0 change in payments. The estimated changes shown in this column reflect the combined effects of the changes in Columns 2, 3, and 4 and the budget neutrality factors discussed previously.

We estimate that the combined impact of the proposed changes to the relative weights and MS–DRGs and the proposed updated wage data with budget neutrality applied will result in no change in payments for urban or rural hospitals. Urban New England would experience a 0.6 decrease in payments due to reductions in their case-mix and wages compared to the national average, while the urban Pacific area would experience a 0.5 percent increase in payments because of above average increases in wages and case-mix. Among the rural hospital categories, rural South Atlantic hospitals would experience the greatest decline in payment (−0.9 percent) primarily due to the changes to MS–DRGs and the relative cost weights.

H. Effects of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed acute care hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The changes in Column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2011 which affect hospitals' wage index area assignments.

By spring of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. Hospitals may appeal denials of MGCRB decisions to the CMS Administrator. Further, hospitals have 45 days from publication of the IPPS rule in the **Federal Register** to decide whether to withdraw or terminate an approved geographic reclassification for the following year. This column reflects all MGCRB decisions, Administrator appeals and decisions of hospitals for FY 2011 geographic reclassifications.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, for the purposes of this impact analysis, we are applying an adjustment of 0.991756 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral (section II.A. of the Addendum to this proposed rule). Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.6 percent. By region, all the rural hospital categories will experience increases in payments due to MGCRB reclassification where rural hospitals in the Mountain region will experience a 0.1 percent increase in payments and rural hospitals in the East South Central region will experience a 2.4 percent increase in payments.

Table 9A of the Addendum to this proposed rule reflects the approved reclassifications for FY 2011.

I. Effects of the Rural Floor and Imputed Floor, Including Application of Budget Neutrality at the State Level (Column 7)

As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule, the FY 2010 IPPS/RY 2010 LTCH final rule and this proposed rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 final rule, we finalized the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals received a blended wage

index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, hospitals received a blended wage index that is 50 percent of a wage index with the State level rural and imputed floor budget neutrality and 50 percent of a wage index with the national budget neutrality adjustment. For FY 2011, for purposes of this impact analysis, we assume application of the third year of the transitional period so that wage indices adjusted for the rural floor will have 100 percent of the wage index adjusted with a within-State rural budget neutrality factor. However, we recognize that this policy was recently changed by the provisions of section 3141 of Public Law 111–148.

Furthermore, the FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed floor was established for States that do not have rural areas or rural IPPS hospitals. In the FY 2008 IPPS final rule with comment period (72 FR 47321), we finalized our proposal to extend the imputed floor for 1 additional year. In the FY 2009 IPPS final rule (73 FR 48573), we extended the imputed floor for an additional 3 years through FY 2011. Furthermore, as noted above, in that final rule we provided for a 3-year transition to the rural floor budget neutrality adjustment at the State level. Therefore, we also apply the imputed floor budget neutrality adjustment at the State level through a 3-year transition, so that, for FY 2011, wage indices adjusted for the imputed floor will have 100 percent of the wage index computed using the within-State rural and imputed budget neutrality adjustment.

Column 7 shows the projected impact of the rural floor and the imputed floor and the within-State rural and imputed floor budget neutrality. The column compares the proposed post-reclassification FY 2011 wage index of providers before the rural floor adjustment and the post-reclassification FY 2011 wage index of providers with the rural floor and imputed floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, in prior years, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) had experienced a decrease in payments due to the budget neutrality adjustment applied nationally. However, because, for FY 2011, this calculation assumes that the rural floor adjusted wage index is made budget neutral through a within-State budget neutrality factor, rural hospitals and urban hospitals located in States that do not benefit from the rural floor will not experience a change in payments attributable to the rural floor. Conversely, all hospitals in States with hospitals receiving a rural floor will have their wage indices downwardly adjusted to achieve budget neutrality within the State.

We project that, in aggregate, rural hospitals will experience a 0.1 percent decrease in payments as a result of the application of rural floor budget neutrality because the rural hospitals located in States with a rural floor do not benefit from the rural floor, but have their wage indexes downwardly adjusted to ensure that the application of the rural floor is budget neutral overall within the State. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because those providers benefit from the rural floor. Urban hospitals in the regions can expect 0 percent change in payments because within each state, the rural floor is budget neutral and increases in payments for providers receiving the rural floor re offset by the within-State budget neutrality factors applied to the wage index of the providers in States with a rural floor. Rural hospitals located in the Pacific area will experience a 0.3 percent decrease in payments because of the rural floor budget neutrality factor in California downwardly adjusts the wage index by 2.4 percent. Rural hospitals located in the Middle Atlantic area will experience a 0.1 percent decrease in payments because of the imputed rural floor budget neutrality factor (0.97946) in New Jersey downwardly adjusts the wage index for rural hospitals by approximately 2 percent.

J. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 8)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, small rural DSH providers with less than 100 beds will experience a 0.5 percent increase in payments in FY 2011 relative to no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $20 million.

K. Effects of All Proposed Changes Prior to Documentation and Coding (or CMI) Adjustment (Column 9)

Column 9 shows our estimate of the changes in payments per discharge from FY 2010 and FY 2011, resulting from all proposed changes reflected in this proposed rule for FY 2011 (including statutory changes), other than the proposed documentation and coding adjustment. Column 9 reflects the impact of all other FY 2011 changes relative to FY 2010, including those shown in Columns 1 through 8. The average increase in payments under the IPPS for all hospitals is approximately 2.8 percent. In addition, it reflects the estimated 0.5 percentage point difference between the projected outlier payments in FY 2010 (5.1 percent of total MS–DRG payments), the current estimate of the percentage of actual outlier payments in FY 2010 (4.7 percent) as described in the introduction to this Appendix and the Addendum to this proposed rule.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 9 may not equal the sum of the percentage changes described above.

L. Effects of All Proposed Changes With CMI Adjustment (Column 10)

Column 10 shows our estimate of the changes in payments per discharge from FY 2010 and FY 2011, resulting from all proposed changes reflected in this proposed rule for FY 2011 (including statutory changes). This column includes the proposed FY 2011 documentation and coding adjustment of −2.9 percent on the national standardized amount, −2.9 percent on the hospital-specific rates, and −2.4 percent on the Puerto Rico-specific standardized amount, which overall accounts for a 2.9 percent decrease in payments.

Column 10 reflects the impact of all proposed FY 2011 changes relative to

FY 2010, including those shown in Columns 1 through 9. The average decrease in payments under the IPPS for all hospitals is approximately −0.1 percent. As described in Column 9, this average decrease includes the effects of the 2.4 percent market basket update, the 0.5 percentage point difference between the projected outlier payments in FY 2010 (5.1 percent of total MS–DRG payments), and the current estimate of the percentage of actual outlier payments in FY 2010 (4.7 percent). There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 10 may not equal the sum of the percentage changes described above.

The overall proposed change in payments per discharge for hospitals paid under the IPPS in FY 2011 is estimated to decrease by 0.1 percent. The payment decreases among the hospital categories are largely attributed to the proposed documentation and coding adjustments. Hospitals in urban areas would experience an estimated 0.1 percent decrease in payments per discharge in FY 2011 compared to FY 2010. Hospital payments per discharge in rural areas are estimated to decrease by 0.5 percent in FY 2011 as compared to FY 2010. The decreases larger than the national average for rural areas are largely attributed to the differential impact of the MS–DRGs and wage data and due to the −2.9 percent documentation and coding adjustment applied to the national standardized amount and the −2.9 percent documentation and coding adjustment to the hospital-specific rate applied to SCHs and MDHs, which generally are classified as rural hospitals.

Among urban census divisions, the largest estimated payment decreases will be 0.9 percent in the New England region and 0.6 percent in the Middle Atlantic region, while urban hospitals in the Pacific will see the largest payment increases (0.5 percent). Among the rural regions, the providers in the New England region will experience the largest decrease in payments (1.6 percent) because of reductions due to case-mix and the documentation and coding adjustments while rural hospitals in the West South Central region will experience an increase in payments by 0.4 percent due to increases in case-mix, wage data and MGCRB reclassification.

Among special categories of rural hospitals, MDHs will receive an estimated payment decrease of 0.6 percent. MDHs are paid the higher of the IPPS rate based on the national standardized amount, that is, the Federal rate, or, if the hospital-specific rate exceeds the Federal rate, the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. MDHs will experience a decrease in payments because of the proposed documentation and coding adjustments applied to both the hospital-specific rate and the Federal rate. SCHs are also paid the higher of their hospital-specific rate or the federal rate. Overall, SCHs will experience an estimated decrease in payments by 0.5 percent due to the proposed documentation and coding adjustments to the national standardized amount and the hospital-specific rates.

Rural hospitals reclassified for FY 2011 are anticipated to receive a 0.3 percent payment decrease, and rural hospitals that are not reclassifying are estimated to receive a payment decrease of 0.7 percent.

Cardiac hospitals are expected to experience a payment increase of 0.8 percent in FY 2011 relative to FY 2010 due to increases in payments attributable to changes in the MS–DRGs and relative weights.

M. Effects of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2011, we are proposing to continue to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that three providers will receive the low-volume adjustment for FY 2011. We estimate that low-volume hospitals will experience an increase of $114,000 in payments due to the low volume payment adjustment.

N. Impact Analysis of Table II

Table II presents the projected impact of the proposed changes for FY 2011 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated average payments per discharge for FY 2010 with the proposed payments per discharge for FY 2011, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the proposed changes presented in Table I. The estimated percentage changes shown in the last column of Table II equal the estimated percentage changes in average payments per discharge from Column 10 of Table I.

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TABLE II.--IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2011 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER DISCHARGE)

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
All hospitals	3,472	$10,179	$10,166	-0.1
By Geographic Location:				
Urban hospitals	2,502	$10,607	$10,598	-0.1
Large urban areas (populations over 1 million)	1,365	$11,193	$11,181	-0.1
Other urban areas (populations of 1 million or fewer)	1,137	$9,888	$9,882	-0.1
Rural hospitals	970	$7,577	$7,536	-0.5
Bed Size (Urban):				
0-99 beds	635	$8,056	$8,057	0
100-199 beds	791	$8,926	$8,908	-0.2
200-299 beds	461	$9,861	$9,842	-0.2
300-499 beds	425	$10,995	$10,984	-0.1
500 or more beds	190	$13,104	$13,113	0.1
Bed Size (Rural):				
0-49 beds	337	$6,136	$6,137	0
50-99 beds	366	$7,088	$7,030	-0.8
100-149 beds	164	$7,485	$7,458	-0.4
150-199 beds	61	$8,274	$8,249	-0.3
200 or more beds	42	$9,405	$9,331	-0.8
Urban by Region:				
New England	121	$11,035	$10,937	-0.9
Middle Atlantic	330	$11,677	$11,611	-0.6
South Atlantic	383	$9,841	$9,827	-0.1
East North Central	403	$9,967	$9,975	0.1
East South Central	155	$9,510	$9,475	-0.4
West North Central	166	$10,131	$10,138	0.1
West South Central	342	$9,931	$9,961	0.3
Mountain	162	$10,836	$10,841	0
Pacific	390	$13,032	$13,092	0.5
Puerto Rico	50	$5,133	$5,149	0.3
Rural by Region:				
New England	24	$9,980	$9,817	-1.6
Middle Atlantic	70	$7,939	$7,874	-0.8
South Atlantic	165	$7,348	$7,271	-1
East North Central	120	$7,854	$7,800	-0.7
East South Central	175	$6,872	$6,856	-0.2

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
West North Central	100	$8,013	$8,003	-0.1
West South Central	214	$6,805	$6,835	0.4
Mountain	71	$8,195	$8,184	-0.1
Pacific	31	$10,340	$10,186	-1.5
By Payment Classification:				
Urban hospitals	2,555	$10,584	$10,575	-0.1
Large urban areas (populations over 1 million)	1,403	$11,171	$11,159	-0.1
Other urban areas (populations of 1 million or fewer)	1,152	$9,859	$9,853	-0.1
Rural areas	917	$7,638	$7,596	-0.5
Teaching Status:				
Non-teaching	2,434	$8,547	$8,537	-0.1
Fewer than 100 Residents	798	$10,088	$10,066	-0.2
100 or more Residents	240	$15,040	$15,033	0
Urban DSH:				
Non-DSH	834	$8,866	$8,866	0
100 or more beds	1,510	$11,163	$11,153	-0.1
Less than 100 beds	340	$7,594	$7,558	-0.5
Rural DSH:				
SCH	407	$7,022	$6,983	-0.6
RRC	209	$8,414	$8,362	-0.6
100 or more beds	30	$6,589	$6,547	-0.6
Less than 100 beds	142	$5,898	$5,854	-0.7
Urban teaching and DSH:				
Both teaching and DSH	806	$12,188	$12,173	-0.1
Teaching and no DSH	169	$9,705	$9,686	-0.2
No teaching and DSH	1,044	$9,130	$9,123	-0.1
No teaching and no DSH	536	$8,468	$8,482	0.2
Rural Hospital Types:				
RRC	183	$8,527	$8,493	-0.4
SCH	340	$7,998	$7,956	-0.5
MDH	187	$6,325	$6,288	-0.6
SCH and RRC	108	$9,479	$9,407	-0.8
MDH and RRC	13	$8,007	$7,955	-0.6
Type of Ownership:				
Voluntary	1,978	$10,331	$10,310	-0.2
Proprietary	837	$9,122	$9,132	0.1
Government	577	$10,688	$10,681	-0.1

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	$13,589	$13,576	-0.1
25-50	1593	$11,094	$11,088	-0.1
50-65	1202	$8,511	$8,483	-0.3
Over 65	237	$7,455	$7,438	-0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2011 Reclassifications:				
All Reclassified Hospitals FY 2011	810	$9,903	$9,889	-0.1
All Non-Reclassified Hospitals FY 2011	2,662	$10,282	$10,268	-0.1
Urban Reclassified Hospitals FY 2011:	488	$10,557	$10,549	-0.1
Urban Non-reclassified Hospitals FY 2011:.....	1,985	$10,632	$10,623	-0.1
Rural Reclassified Hospitals FY 2011:.....:	322	$8,173	$8,145	-0.3
Rural Nonreclassified Hospitals FY 2011:	585	$6,872	$6,822	-0.7
All Section 401 Reclassified Hospitals:	37	$8,923	$8,825	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	$7,276	$7,190	-1.2
Specialty Hospitals				
Cardiac Hospitals	19	$11,496	$11,584	0.8

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VII. Effects of Other Proposed Policy Changes

In addition to those proposed policy changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing to make various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Effects of Proposed Policy on HACs, Including Infections

In section II.F. of the preamble of this proposed rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision results in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case. In addition, as discussed in section II.F.3.e. of the preamble of this proposed rule, it is possible to have two severity levels where the HAC does not affect the MS–DRG assignment or for an MS–DRG not to have severity levels. In either of these circumstances, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case.

The HAC payment provision went into effect on October 1, 2008. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings (in millions)
FY 2011	23
FY 2012	24
FY 2013	25
FY 2014	26
FY 2015	26

B. Effects of Proposed Policy Relating to New Medical Service and Technology Add-On Payments

In section II.I. of the preamble to this proposed rule, we discuss the three applications for add-on payments for new medical services and technologies for FY 2011, as well as the status of the new technologies that were approved to receive new technology add-on payments in FY 2010. As explained in that section, add-on payments for new technology under section 1886(d)(5)(K) of the Act are not required to be budget neutral. As discussed in section II.I.4. of the preamble of this proposed rule, we have yet to determine whether any of the three applications we received for consideration for new technology add-on payments for FY 2011 will meet the specified criteria. Consequently, it is premature to estimate the potential payment impact of any potential new technology add-on payments for FY 2011. We note that if any of the three applications are found to be eligible for new technology add-on payments for FY 2011, in the FY 2011 IPPS/LTCH PPS final rule, we would discuss the estimated payment impact for FY 2011 in that final rule.

However, we are proposing to continue to make new technology add-on payments in FY 2011 for the Cardiowest™ Temporary Total Artificial Heart System (TAH-t) and the Spiration® IBV® Valve System. Therefore, we are providing an estimate of total payments for these technologies in FY 2011. We note that new technology add-on payments per case are limited to the lesser of: (1) 50 percent of the costs of the new technology; or (2) 50 percent of the amount by which the costs of the case exceed the standard MS–DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, our estimate below is based on the increase in add-on payments for FY 2011 as if every claim that would qualify for a new technology add-on payments would receive the maximum add-on payment. Therefore, we currently estimate that payments for the TAH-t will increase overall FY 2011 payments by $9.54 million. For FY 2010, the applicant estimated that approximately 2,286 Medicare beneficiaries would be eligible for the Spiration® IBV® Valve System. Therefore, based on the applicant's estimate from FY 2010, we currently estimate that payments for the Spiration® IBV® Valve System will increase overall FY 2011 payments by $7.80 million.

C. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In Appendix A, section VII.C. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44224), we discussed the impact of the FY 2011 RHQDAPU program requirements. In this proposed rule, we are proposing to retire one of the FY 2011 quality measures. We believe that this proposal would not have a significant effect on our previous analysis. We note that, in that final rule, we estimated that 96 hospitals would not receive the full payment update in FY 2010 and that 96 hospitals would not receive the full payment update in FY 2011. As noted above, at the time this analysis was prepared, 104 hospitals did not receive the full payment update in FY 2010.

In section IV.A. of the preamble of this proposed rule, we discuss our proposed requirements for hospitals to report quality data under the RHQDAPU program in order to receive the full payment update for FY 2012, FY 2013, and FY 2014. We estimate that approximately 104 hospitals may not receive the full payment update in any fiscal year. We believe that most of these hospitals would be either small rural or small urban hospitals. However, at this time, information is not available to determine the hospitals that will not meet the requirements for the full hospital market basket increase for FY 2012, FY 2013, and FY 2014.

For the FY 2012 payment determination, hospitals would be required to submit all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures. The submission of all-patient volume data will occur free of charge to hospitals. Therefore, the additional resource burden to hospitals for this requirement is expected to be minimal. For the FY 2013 payment determination, we have proposed that hospitals will choose one of four proposed registry-based topics for which there are currently a number of nationwide registries each individually collecting data from a significant proportion of IPPS hospitals. We have proposed that hospitals will submit data on proposed measures included within the proposed registry-based topic to a registry that we qualify for this purpose.

For the proposed ICD Complications registry-based topic, currently, 100 percent of hospitals performing ICD implantation participate in the American College of Cardiology-National Cardiovascular Data Registry's (ACC–NCDR) ICD registry and 78 percent of those hospitals are already submitting the additional data elements and secondary population needed to calculate the ICD complication measure. For the proposed Cardiac Surgery registry-based topic, we have estimated that 80 to 90 percent of hospitals performing cardiac surgery currently participate in a cardiac surgery registry. Therefore, the number of additional hospitals not currently participating in a cardiac surgery registry that would choose this topic is expected to be minimal. For the proposed Stroke and Nursing Sensitive Care registry-based topics, there are a number of registries to which at least 25 percent of IPPS hospitals currently submit data. We currently do not know if hospitals would choose one of these two proposed topics if they are not already submitting data to one of these registries. The AMI-statin at discharge measure, proposed for FY 2013 payment determination, would create minimal additional burden as hospitals can collect the data elements from the same charts already being pulled for existing RHQDAPU program AMI measures.

For the FY 2014 payment determination, the proposed addition of four chart-abstracted measures that require hospitals to submit data on all inpatients is expected to create an additional burden for hospitals. The information needed for the proposed ED–Throughput measures is captured as routine documentation, and therefore is not expected to impose much additional burden. The proposed Global Immunization measures would require hospitals to collect information on all inpatients regarding flu and pneumonia vaccinations that they are currently only collecting for patients admitted for pneumonia. Therefore, the number of patients for which these data would need to be collected will increase.

We also note that, beginning with the FY 2012 payment update, hospitals must pass our validation requirement of a minimum of 75 percent reliability, based upon our chart-audit validation process, for three quarters of data from the first quarter of CY 2010 through the third quarter of CY 2010. These data are due to the QIO Clinical Warehouse by August 15, 2010 (first quarter CY 2010 discharges), November 15, 2010 (second quarter CY 2010 discharges), and February 15, 2011 (third quarter CY 2010 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to participate in the RHQDAPU program. The requirement of 12 charts per hospital submitted for validation would result in approximately 9,600 charts per quarter being submitted to CMS. We reimburse hospitals for the cost of

sending charts to the Clinical Data Abstraction Center (CDAC) contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, as a result of the validation requirements we are proposing for the FY 2012 annual payment update, we estimate that CMS would have expenditures of approximately $212,000 per quarter, which is a reduction from the $597,600 per quarter to collect the charts for the FY 2010 and FY 2011 annual payment updates. Given that we reimburse for the data collection effort, we believe that a requirement for 12 charts per hospital per quarter represents a minimal burden to participating hospitals.

We have finalized a new validation methodology for FY 2012. We believe that these modifications will not change the number of hospitals that fail the validation requirement for FY 2012 from previous years. We are changing the way we calculate the validation matches (that is, all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match), which will make it more difficult for hospitals to satisfy the validation requirement. However, we also will validate data for a smaller number of hospitals each year and we changed the validation threshold from 80 percent to 75 percent. In addition, we conducted analysis in FY 2010 of past validation data and found that at least 95 percent of sampled hospitals are expected to pass the 75 percent validation threshold starting in FY 2012. In combination, we believe that these proposed revisions will counterbalance each other and result in no additional impact to the number of hospitals failing our validation requirement for FY 2012.

If we determine that a hospital is not entitled to receive the full FY 2012 payment update because it failed to satisfy the validation requirement, and the hospital asks for a reconsideration of that decision, we are proposing that the hospital submit complete copies of the medical records that it submitted to the CDAC contractor for purposes of the validation for which the hospital incurs the cost. We estimate that no greater than 40 hospitals would fail this requirement for FY 2012. We estimate that this proposal would cost hospitals approximately 12 cents per page for copying and approximately $4.00 per chart for postage. We have found, based on experience, that an average sized medical chart is approximately 150 pages. Hospitals would be required to return all 36 sampled medical records for the three quarters of data from FY 2010. We estimate that the total cost to the 40 impacted hospitals would be approximately $17,600, or $440 per hospital. We believe that this cost is minimal, compared with the 2.0 percent RHQDAPU program component of the annual payment update at risk. This proposed requirement is necessary so that CMS has all the information it needs to fairly and timely make a decision on the hospital's reconsideration request. We also anticipate that this proposed requirement would benefit hospitals seeking a reconsideration because it will enable us to resolve potential issues earlier in the appeals process, obviating the need for a hearing before the Provider Reimbursement Review Board (PRRB). We believe that this benefit would greatly outweigh the burden of copying and mailing the requested records.

We note that, beginning with FY 2014 and future years, we are considering adding two stratum to the current RHQDAPU validation sample of SCIP, AMI, HF, and PN cases. We will consider selecting two additional samples of three cases per selected hospital per quarter to validate proposed surgical site infection, blood stream infection, ED-Throughput and Global Immunization measures. If we later propose this requirement and adopt it as final through rulemaking, we would randomly select a total of 18 records per quarter per validated hospital in 6 strata (SCIP, AMI, HF, PN, CLABSI/SSI, and ED-Throughput/Immunization measures). The requirement of an additional 6 charts per hospital submitted for validation would result in approximately 4,800 additional charts per quarter being submitted to CMS. We reimburse hospitals for the cost of sending charts to the CDAC contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, we would expend approximately $105,600 per quarter to collect the charts for the annual payment update for FY 2014 and future years. Given that we reimburse for the data collection effort, we believe that a proposed requirement of the additional records in FY 2014 per hospital per quarter represents a minimal burden to the participating hospital.

D. Effects of Proposed Policy on Payment for Transfer Cases From Medicare Participating Hospitals to Nonparticipating Hospitals and CAHs

In section IV.B. of the preamble of this proposed rule, we are proposing to expand the acute care transfer policy to transfers to nonparticipating acute care hospitals and to CAHs. This proposed expansion of the acute care transfer policy aims to further align the policy with its original intent, that is, to pay a hospital commensurate with the resources it expends in treating a Medicare beneficiary who is transferred. However, the impacts of this change are not possible to measure, although we believe the any change in Medicare payments to hospitals associated with this proposed change would be negligible. Specifically, because there are relatively few nonparticipating acute care hospitals, we expect that there would be few, if any, transfers to nonparticipating hospitals in a given period. In addition, based on the capped inpatient bed size of CAHs (that is, not more than 25 inpatient beds) and the CAH distance requirements (that is, a CAH must generally be located at least 35 miles from another hospital), we believe that transfers from an IPPS acute care hospital to a CAH occur very infrequently. Therefore, we estimate that this proposed expansion of the acute care transfer policy would not have a material impact on Medicare payments to acute care hospitals.

E. Effects of Proposed Change in Criteria for MDHs

In section IV.D. of the preamble of this proposed rule, we discuss our proposal to revise the existing Medicare-dependency criterion for MDHs at § 412.108(a)(1)(iii) of the regulations (that is, "At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period. * * *") by replacing the word "receiving" with the phrase "entitled to". As a result, we would include in the count of Medicare inpatient days or discharges, all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A hospital inpatient coverage benefit.

Based on our analysis of data for cost reporting periods beginning in FYs 2007 and 2008, we estimate that the proposed change to the MDH definition of Medicare-dependency may allow 48 more IPPS hospitals to qualify as an MDH. We estimate that this proposed

change would result in increased expenditure of $3.6 million in FY 2011. (We note that the PPACA (Pub. L. 111–148) extended the sunset date for MDHs from the end of FY 2011 to the end of FY 2012. We plan to issue a separate rulemaking document in the **Federal Register** to address this statutory provision.

F. Effects of Proposed Change Relating to Payment Adjustment for Disproportionate Share Hospitals

In section IV.E. of the preamble of this proposed rule, we are proposing to change, effective for FY 2011 and subsequent years, the data matching process used to calculate the SSI fraction for the Medicare DSH payment adjustment. The SSI fraction is part of the formula used to determine whether a subsection (d) hospital qualifies for a DSH payment adjustment and the amount of any DSH payment.

The numerator of a hospital's DSH SSI fraction is the number of inpatient days for the provider's patients who were entitled to both Medicare Part A and SSI benefits. The denominator of the hospital's SSI fraction is the total number of inpatient days for the provider's patients who were entitled to Part A benefits. In order to calculate the numerator of a hospital's DSH SSI fraction, CMS matches certain Medicare data files with SSI eligibility data files that are furnished by SSA. In Baystate Medical Center v. *Leavitt* (545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008)), the district court concluded that, in certain respects, CMS' current matching process did not use the "best available data" to match Medicare patient day information with SSI eligibility data. In implementing the *Baystate* decision, CMS recalculated the plaintiff's SSI fractions and DSH payments for its FYs 1993 through 1996 by using a revised data matching process that comports with the district court's decision.

We are now proposing to adopt the same revised data matching process for calculating hospitals' DSH SSI fractions for FY 2011 and subsequent fiscal years. In addition, we are proposing to use, in the revised matching process, a later update of the MedPAR claims data file and the SSI eligibility data file. Specifically, we are proposing to use MedPAR claims files and SSI eligibility data that are updated 15 months after the end of the Federal fiscal year, rather than continue with our current practice of using data updated 6 months after the end of the Federal fiscal year. We believe that our proposed revision to the timing of the data match would achieve an appropriate balance between accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions and facilitating administrative finality through the timely final settlement of Medicare cost reports.

We are not able to provide a detailed analysis of the potential impact of the proposed revised data matching process. That is, it is not possible to determine whether Medicare DSH adjustment payments to hospitals will generally increase or decrease, because hospitals' SSI fractions will vary depending on various factors, including the use of a more updated MedPAR claims data file, use of a more updated SSI eligibility data file, and the other features of our proposed revised data matching process.

With respect to the use of a more updated MedPAR claims data file, we expect that using a later version of the MedPAR claims file would increase the number of inpatient claims for a given Federal fiscal year and, therefore, would increase the number of Medicare inpatient days included in the denominator of the SSI fraction. Depending on whether or not the additional claims in the MedPAR file were for Medicare patients who were also eligible for SSI during the inpatient stay, the numerator of the SSI fraction might increase or decrease.

As for the use of an updated SSI eligibility file, we note that retroactive SSI eligibility determinations include both the granting and the denial of SSI benefits. Therefore, assuming that some of the retroactive SSI eligibility determinations were for Medicare patients, the use of an updated SSI eligibility file also could increase or decrease the numerator of the SSI fraction. We expect that, as a result of using an updated SSI eligibility file, the SSI fraction for some hospitals would increase while it would decrease for other hospitals.

We also note that, in the *Baystate* decision, the district court found that certain records (for example, "stale records" and "forced pay records") were not included in the SSI eligibility data that SSA gave to CMS for use in the data matching process. However, the SSI eligibility data files began to include certain of these records in the mid-1990's, and stale records and forced pay records were included in the SSI eligibility data files that CMS used in recalculating the specific SSI fractions and DSH adjustment payments at issue in the Baystate case. As certain of these records are already included in the data matching process and we are making no proposals that would change this policy, we are unable to determine if this issue has any cost or savings for FY 2011 and subsequent years.

Finally, our proposed revised data matching process includes the use of SSNs and a greater number of Title II numbers and HICANs. As a result, we might be able to identify some individuals who were entitled to both Part A and SSI benefits that our current data matching process might not have identified. Therefore, we would expect an increase in the SSI fraction for certain providers, but we are unable to determine the extent to which DSH adjustment payments would increase.

G. Effects of Proposed Changes Relating to Payments for IME and Direct GME

1. Identifying "Approved Medical Residency Programs"

In section IV.H.2. of the preamble of this proposed rule, we discuss our proposal to clarify our policy regarding whether an individual is considered to be training in an approved medical residency program such that the individual's time should be included in the FTE count for IME and direct GME purposes, or whether that individual should be treated and bill as a physician. Specifically, our proposed clarification states that individuals should be treated as and bill as physicians if they have already successfully completed at least one residency program (regardless of whether they have passed the board examination for that specialty program), and are engaged in subsequent training that will not provide them with knowledge or skills that could be applied for additional board certification in another subspecialty, nor do they need that training to satisfy requirements for board certification in the specialty program they already successfully completed. We also are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

With respect to the policy regarding the treatment of trainees that have already successfully completed at least one residency program, there is no financial impact on the Medicare program because this is a proposed clarification of existing policy and is not a policy revision or addition of a new policy. The proposed policy change to the regulations might have some limited financial impact to the extent that a hospital previously included trainees

who were not formally enrolled in an approved program in its FTE counts, and as a result of the proposed change to the regulations, would no longer be able to include such trainees in its FTE count for IME and direct GME purposes. However, we believe it would be rare for a hospital to have included in its FTE count trainees who are not formally enrolled in a residency program in the typical fashion. Further, we believe that it would be rare for such a hospital to have sufficient room under its IME and direct GME FTE resident caps to include any such "informally enrolled" residents in addition to the typically enrolled residents. Thus, the financial impact of the proposed change in the regulatory definition of "resident" would be insignificant.

2. Submission of Electronic Affiliation Agreements

In section IV.H.3. of the preamble of this proposed rule, we discuss our proposal to allow hospitals to submit Medicare GME affiliation agreements to the CMS Central Office by electronic submission. Over the last several years, we have received numerous inquiries regarding the possibility of submitting the Medicare GME affiliation agreement electronically. To date, CMS has only accepted signed hard copies of Medicare GME affiliation agreements that are received through the mail. Facsimile (FAX) and other electronic submissions of affiliation agreements have not been an acceptable means of transmission of affiliation agreements to CMS Central Office in order for a hospital to meet the requirements of §§ 413.79(f) and 412.105(f)(1)(vi).

The increasing frequency of these inquiries and our concerns regarding environmental and paperwork reduction have prompted us to reconsider our procedure for hospitals to submit Medicare GME affiliation agreements to the CMS Central Office. Accordingly, we are proposing to change our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. This proposal would not affect the authority of the fiscal intermediary or MAC to continue to specify its requirements for submission for hospitals in its servicing area.

We are proposing an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a PDF version of that hard copy agreement. We are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75.

We believe that allowing an electronic submission of the affiliation agreement to the CMS Central Office would assist us in more effectively tracking the groups of hospitals that become an affiliation as well as the numbers of FTE cap slots that are being transferred within those groups. In addition, we believe an electronic submission process would minimize the paperwork burden for hospitals.

H. Effects of Proposed Changes Relating to CRNA Services Furnished in Rural Hospitals and CAHs

In section IV.I. of the preamble of this proposed rule, we discuss our proposal to amend the regulations at § 412.113(c)(2)(i)(A) to state that, effective for cost reporting periods beginning on or after October 1, 2010, hospitals and CAHs that have reclassified under section 1886(d)(8)(E) of the Act and § 412.103 are eligible to be paid based on reasonable cost for anesthesia and related care furnished by qualified nonphysician anesthetists. Under existing regulations, a hospital or CAH is not eligible to be paid based on reasonable cost for anesthesia and related care furnished by qualified nonphysician anesthetists if the hospital or CAH has been granted rural status under § 412.103. However, because the Act, as revised by section 608 of Public Law 100–485, allows for reasonable cost payments for CRNA services if the facility is a hospital located in a rural area as defined for purposes of section 1886(d) of the Act, we are proposing to revise the regulations to permit urban hospitals that have been reclassified as rural, in accordance with section 1886(d)(8)(E) of the Act, to qualify for these payments. We are proposing to revise the regulations to state that, effective for cost reporting periods beginning on or after October 1, 2010, hospitals and CAHs that have reclassified pursuant to section 1886(d)(8)(E) of the Act and § 412.103 of the regulations would be eligible to be paid based on reasonable cost for anesthesia services and related care provided by qualified nonphysician anesthetists.

We believe it is difficult to quantify the payment impact of this proposed change because, in order to qualify for reasonable cost-based payment for anesthesia and related services provided by qualified nonphysician anesthetists, a rural hospital or CAH cannot exceed an annual limit of 800 surgical procedures requiring anesthesia. We cannot establish the number of facilities that would meet this threshold. In addition, although a hospital or CAH may contract with more than one qualified nonphysician anesthetist and be paid based on reasonable cost for anesthesia and related services performed by these nonphysician anesthetists, the total number of hours of service furnished by the nonphysician anesthetists may not exceed 2,080 hours annually. We also cannot determine the number of facilities that would exceed this threshold. Therefore, while we believe the impact would be relatively minor, we are unable to quantify the impact of the proposed change.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.J. of the preamble of this proposed rule, we discuss our implementation of section 410A of Public Law 108–173, which requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that "[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." As discussed in section IV.J. of the preamble of this proposed rule, in the IPPS final rule for each of the previous 6 fiscal years, we have estimated the additional payments as a result of the demonstration for each of the participating hospitals. In order to achieve budget neutrality, we are proposing to adjust the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that "aggregate payments made by the

Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented" but does not identify the range across which aggregate payments must be held equal.

An extension of this demonstration has been mandated by the Patient Protection and Affordable Care Act (Pub. L. 111–148). The provisions of Public Law 111–148 will be addressed in a separate notice in the **Federal Register**. For this proposed rule, because the mandated period for the demonstration was scheduled to end by the end of FY 2010, we are proposing no additional payment offset for upcoming years of the demonstration. However, we are proposing to make an adjustment in the FY 2011 IPPS final rule to the national IPPS rates to account for any differences between the cost of the demonstration program for hospitals participating in the demonstration during FY 2007, represented by their cost reports beginning in FY 2007, and the amount that was offset by the budget neutrality adjustment for FY 2007. The specific numeric value associated with the proposed adjustment to the national IPPS rates cannot be known until cost reports beginning in FY 2007 of the hospitals participating during FY 2007 in the demonstration are settled. We expect those cost reports to be settled prior to the publication of the FY 2011 IPPS final rule, and that we will be able to provide an estimated amount in the FY 2011 IPPS final rule.

J. Effects of Proposed Changes Relating to CAHs

1. CAH Optional Method of Payment for Outpatient Services

In section VI.B.2. of the preamble of this proposed rule, we discuss our proposal to amend the regulations to permit a CAH to elect to be paid for outpatient services under the optional method on a continuous basis. Under existing regulations, if a CAH wishes to be paid under the optional method for outpatient services on a continuous basis, it must submit an annual election to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the cost reporting period for which the election is made. Due to the significant consequences that result if a CAH fails to make a timely election, we are proposing to amend the regulations at § 413.70(b)(3)(i) to state that, effective for CAH cost reporting periods beginning on or after October 1, 2010, if a CAH has elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010, or chooses to elect the optional method for its upcoming cost reporting period, that election will remain in place until it is terminated. If a CAH chooses to terminate its election, it must submit a termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. In order to provide CAHs that have cost reporting periods beginning in October or November 2010 time to choose to terminate an existing election of the optional method, we are proposing that these CAHs would have until December 1, 2010, to terminate their election. We anticipate that there would be no additional Medicare expenditure associated with this proposed change because we are not proposing any changes that govern payment rules for CAHs. Rather, we believe the regulatory changes we are proposing would reduce any perceived burden associated with the election process and make it easier for CAHs to maintain their election of the optional method on a continuous basis.

2. Consideration of Costs of Provider Taxes as Allowable Costs for CAHs

In section VI.B.3. of the preamble of this proposed rule, we discuss our proposal to clarify our policy on the determination of whether the costs of property taxes are allowable costs under Medicare, as described in sections 2212.1 and 2212.2 of the PRM. This is a clarification of our longstanding policy. Therefore, we have determined that there is no financial impact of the proposed change.

K. Effects of Proposed Policy Relating to Effective Date of Provider Agreements and Supplier Approvals

In section VIII. of the preamble of this proposed rule, we discuss our proposal to clarify the requirements supporting the existing process for assignment of an effective date for a provider agreement or supplier approval. Approximately 54,500 Medicare providers and suppliers are subject to survey and certification requirements under this proposal. However, the proposed clarification would not change the process for providers and suppliers. Therefore, the impact of our proposed clarification is negligible.

L. Effects of Proposed Changes Relating to Hospital Rehabilitation Services and Respiratory Care Services Conditions of Participation

In section IX. of the preamble of this proposed rule, we discuss our proposed changes to the conditions of participation for hospital rehabilitation services and respiratory care services to clarify the categories of practitioners allowed to order rehabilitation services and respiratory care services. We believe that this proposal would impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings due to the regulatory flexibility of these proposed changes, which may allow for greater consistency with existing State laws and with hospital policies and procedures. The cost of implementing these proposed changes would largely be limited to the one-time cost related to the revision of a hospital's medical staff bylaws and its policies and procedures as they relate to the proposed requirements for the categories of practitioners allowed to order rehabilitation and respiratory care services. There also may be some minimal cost associated with communicating these changes to affected hospital staff.

However, we believe that these costs would be offset by the benefits derived from the overall intent of this proposed clarification to allow qualified, licensed practitioners, who are authorized by the medical staff, to order these services as long as they are responsible for the care of the patient for whom they are ordering the services and as long as such privileges are in accordance with hospital policies and applicable State laws and regulations. Furthermore, the proposed changes would clarify existing hospital conditions of participation to make them more consistent not only with each other, but also with many State laws and with current practice. Therefore, while this proposal would impose a minimal burden on hospitals, we believe that, in sum, the changes proposed would greatly benefit hospitals overall.

VIII. Effects of Proposed Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (§ 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a

proportion of the capital Federal rate (§ 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

The basic methodology for determining a capital IPPS payment is set forth at § 412.312. The basic methodology for calculating capital IPPS payments in FY 2011 is as follows:

(Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME adjustment factor, if applicable).

In addition to the other adjustments, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2009 update of the FY 2009 MedPAR file and the December 2009 update of the Provider-Specific File (PSF) that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2009 update of the most recently available hospital cost report data (FYs 2006 and 2007) to categorize hospitals. Our analysis has several qualifications. We use the best data available and make assumptions about case-mix and beneficiary enrollment as described below. In addition, as discussed in section V.E. of the preamble of this proposed rule, we are proposing a −2.9 percent documentation and coding adjustment to the capital Federal rate for FY 2011, in addition to the −0.6 percent adjustment established for FY 2008 and the −0.9 percent adjustment for FY 2009. This proposal results in a cumulative adjustment factor of 0.957 that we are proposing to apply to the capital Federal rate to account for improvements in documentation and coding under the MS–DRGs in FY 2011. We also are proposing to adjust the Puerto Rico-specific capital rate in FY 2011 by −2.4 percent to account for changes in documentation and coding resulting from the adoption of the MS–DRGs.

Due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. In addition, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2009 update of the FY 2009 MedPAR file, we simulated payments under the capital PPS for FY 2010 and FY 2011 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum to this proposed rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2010 and 2011.
- We estimate that the Medicare discharges will be approximately 11.8 million in FY 2010 and 12.1 million FY 2011.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section III.1.a. of the Addendum to this proposed rule, the proposed FY 2011 update is 1.5 percent.
- In addition to the FY 2011 update factor, the proposed FY 2011 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0000, a proposed outlier adjustment factor of 0.9424, and a proposed (special) exceptions adjustment factor of 0.9997.
- For FY 2011, as discussed above and in section V.E. of the preamble to this proposed rule, we also are proposing to apply a 0.957 adjustment to the proposed FY 2011 capital Federal rate for changes in documentation and coding that are expected to increase case-mix under the MS–DRGs.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2011 on total capital payments per case, using a universe of 3,472 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2009 update of the FY 2009 MedPAR file, the December 2009 update to the PSF, and the most recent cost report data from the December 2009 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2010 compared to FY 2011 based on the proposed FY 2011 payment policies. Column 2 shows estimates of payments per case under our model for FY 2010. Column 3 shows estimates of payments per case under our model for FY 2011. Column 4 shows the total percentage change in payments from FY 2010 to FY 2011. The change represented in Column 4 includes the proposed 1.5 percent update to the capital Federal rate and other proposed changes in the adjustments to the capital Federal rate. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case in FY 2011 are expected to decrease as compared to capital payments per case in FY 2010. The proposed capital Federal rate for FY 2011 would increase 1.5 percent as compared to the FY 2010 capital rate. The proposed changes to the GAFs are expected to result, on average, in a slight decrease in capital payments, although, for rural areas, it is more of a contributing factor to the overall estimated decrease in capital payments than to urban areas mostly due to the application of the rural floor to the wage index. Our impact analysis includes actuarial assumptions of growth from FY 2010 to FY 2011 resulting in a slight increase in capital payments. The net result of these proposed changes is an estimated −0.2 percent change in capital payments per discharge from FY 2010 to FY 2011 for all hospitals (as shown below in Table III).

The geographic comparison shows that, on average, all urban hospitals are expected to experience a 0.2 percent decrease in capital IPPS payments per case in FY 2011 as compared to FY

2010, while hospitals in large urban areas are expected to experience a 0.1 percent decrease in capital IPPS payments per case in FY 2011 as compared to FY 2010. Capital IPPS payments per case for rural hospitals are expected to decrease 0.7 percent.

The change comparisons by regions show some regions experiencing slight increases in total capital payments, while other regions are estimated to experience decreases in capital payments from FY 2010 to FY 2011. For the urban regions, changes in capital payments range from a −1.3 percent for the New England urban region to a 0.5 percent for the Pacific urban region. Estimates for two urban regions, East North Central and West North Central, show no change in total capital payments from FY 2010 to FY 2011. Estimates of changes for the rural regions from FY 2010 to FY 2011 range from a 2.3 percent decrease in capital payments in the New England rural region to a 0.6 percent increase for the West South Central rural region. These regional differences are primarily due to the proposed changes to the GAFs and differences in the estimated increase in outlier payments from FY 2010 to FY 2011.

By type of ownership, proprietary hospitals are estimated to experience an increase of 0.1 percent in capital payments per case, and voluntary hospitals are estimated to experience a 0.3 percent decrease in capital payments per case from FY 2010 to FY 2011. We estimate no change in capital payments per case for government hospitals from FY 2010 to FY 2011.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2011. Reclassification for wage index purposes also affects the GAFs because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2011, we show the average capital payments per case for reclassified hospitals for FY 2010. All classifications of reclassified hospitals are expected to experience a decrease in capital payments per case in FY 2011 as compared to FY 2010. Urban reclassified and rural reclassified hospitals are expected to have a decrease in capital payments of 0.2 percent and 0.3 percent, respectively. Capital payments for urban nonreclassified are estimated to decrease 0.1 percent while rural nonreclassified hospitals are estimated to decrease 1.1 percent. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience a decrease of 1.6 percent in capital payment from FY 2010 to FY 2011.

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2010 Payments Compared To Proposed FY 2011 Payments]

	Number of hospitals	Average FY 2010 payments/ case	Average Proposed FY 2011 payments/ case	Change
By Geographic Location:				
All hospitals	3,472	791	789	-0.2
Large urban areas (populations over 1 million)	1,365	872	871	-0.1
Other urban areas (populations of 1 million of fewer)	1,137	780	778	-0.2
Rural areas	970	549	545	-0.7
Urban hospitals	2,502	831	829	-0.2
0-99 beds	635	656	655	-0.1
100-199 beds	791	714	711	-0.4
200-299 beds	461	782	779	-0.4
300-499 beds	425	854	852	-0.2
500 or more beds	190	1,005	1,007	0.2
Rural hospitals	970	549	545	-0.7
0-49 beds	337	442	442	0.1
50-99 beds	366	509	504	-1.1
100-149 beds	164	554	551	-0.5
150-199 beds	61	600	598	-0.3
200 or more beds	42	670	663	-0.9
By Region:				
Urban by Region	2,502	831	829	-0.2
New England	121	863	852	-1.3
Middle Atlantic	330	885	879	-0.7
South Atlantic	383	783	781	-0.2
East North Central	403	806	806	0.0
East South Central	155	742	739	-0.5
West North Central	166	817	817	0.0
West South Central	342	776	778	0.3
Mountain	162	856	855	-0.1
Pacific	390	987	992	0.5
Puerto Rico	50	373	375	0.4
Rural by Region	970	549	545	-0.7
New England	24	724	708	-2.3
Middle Atlantic	70	565	558	-1.2
South Atlantic	165	540	534	-1.1
East North Central	120	574	569	-0.9
East South Central	175	497	495	-0.4
West North Central	100	562	558	-0.8
West South Central	214	514	517	0.6
Mountain	71	551	553	0.3
Pacific	31	693	685	-1.1
By Payment Classification:				
All hospitals	3,472	791	789	-0.2
Large urban areas (populations over 1 million)	1,403	871	870	-0.1
Other urban areas (populations of 1 million of fewer)	1,152	779	777	-0.2
Rural areas	917	546	542	-0.7
Teaching Status:				
Non-teaching	2,434	674	672	-0.3
Fewer than 100 Residents	798	793	790	-0.4
100 or more Residents	240	1,121	1,122	0.1
Urban DSH:				
100 or more beds	1,510	859	858	-0.1
Less than 100 beds	340	593	589	-0.7
Rural DSH:				
Sole Community (SCH/EACH)	407	480	477	-0.6
Referral Center (RRC/EACH)	209	603	598	-0.8
Other Rural:				
100 or more beds	30	500	495	-1.0
Less than 100 beds	142	453	448	-1.1

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2010 Payments Compared To Proposed FY 2011 Payments]

	Number of hospitals	Average FY 2010 payments/ case	Average Proposed FY 2011 payments/ case	Change
Urban teaching and DSH:				
Both teaching and DSH	806	929	928	-0.1
Teaching and no DSH	169	807	804	-0.4
No teaching and DSH	1,044	717	715	-0.3
No teaching and no DSH	536	731	731	0.0
Rural Hospital Types:				
Non special status hospitals	2,435	834	833	-0.1
RRC/EACH	59	747	743	-0.5
SCH/EACH	38	686	688	0.3
Medicare-dependent hospitals (MDH)	10	472	468	-1.0
SCH, RRC and EACH	13	830	824	-0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2011 Reclassifications:				
All Urban Reclassified	488	835	834	-0.2
All Urban Non-Reclassified	1,985	831	830	-0.1
All Rural Reclassified	322	590	588	-0.3
All Rural Non-Reclassified	585	496	491	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	55	557	548	-1.6
Type of Ownership:				
Voluntary	1,978	807	804	-0.3
Proprietary	837	718	719	0.1
Government	577	795	794	0.0
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	966	967	0.1
25-50	1,593	859	859	-0.1
50-65	1,202	678	674	-0.5
Over 65	237	583	580	-0.5

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IX. Effects of Proposed Payment Rate Changes and Policy Changes Under the LTCH PPS

A. Introduction and General Considerations

In section VII. of the preamble and section V. of the Addendum of this proposed rule, we are setting forth the proposed annual update to the payment rates for the LTCH PPS for FY 2011. In the preamble, we specify the statutory authority for the proposed provisions that are presented, identify those proposed policies where discretion has been exercised, and present rationale for our decisions as well as alternatives that were considered. In this section of Appendix A to this proposed rule, we discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies related to the LTCH PPS that are presented in the preamble of this proposed rule in terms of their estimated fiscal impact on the Medicare budget and on LTCHs.

On March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

Currently, our database of 421 LTCHs includes the data for 77 nonprofit (voluntary ownership control) LTCHs and 301 proprietary LTCHs. Of the remaining 43 LTCHs, 12 LTCHs are government-owned and operated and the ownership type of the other 31 LTCHs is unknown. In the impact analysis, we are using the proposed rates, factors, and policies presented in this proposed rule, including proposed updated wage index values and the labor-related share, and the best available claims and CCR data to estimate the change in payments for FY 2011. The standard Federal rate for RY 2010 is $39,896.65. As discussed in section V.A.2. of the Addendum to this proposed rule, consistent with our historical practice, we are proposing to update the standard Federal rate for FY 2011 by −0.1 percent in order to establish the proposed FY 2011 standard Federal rate at $39,856.75. This includes a proposed market basket update of 2.4 percent and a proposed documentation and coding adjustment of −2.5 percent to account for increases in case-mix that do not reflect real changes in patients' severity of illness associated with the adoption of the MS–LTC–DRGs. Based on the best available data for the 421 LTCHs in our database, we estimate that the proposed update to the standard Federal rate for FY 2011 (discussed in section VII.C. of the

preamble of this proposed rule) and the proposed changes to the area wage adjustment (discussed in section V.B. of the Addendum to this proposed rule) for FY 2011, in addition to an estimated increase in HCO payments and an estimated increase in SSO payments, will result in an increase in estimated payments from RY 2010 of approximately $41 million (or about 0.8 percent). Based on the 421 LTCHs in our database, we estimate FY 2011 LTCH PPS payments to be approximately $4.946 billion, an increase from RY 2010 LTCH PPS payments of approximately $4.905 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this proposed rule is considered a major economic rule, as defined in this section. We note the approximately $41 million for the projected increase in estimated aggregate LTCH PPS payments from RY 2010 to FY 2011 does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which also would affect overall payment changes.

The projected 0.8 percent increase in estimated payments per discharge from RY 2010 to FY 2011 is attributable to several factors, including the proposed −0.1 percent decrease to the standard Federal rate, proposed changes in the wage index values (including the proposed change to the labor-related share) and projected increases in estimated HCO and SSO payments. As Table IV shows, the proposed change attributable solely to the standard Federal rate is projected to result in a decrease of 0.1 percent in estimated payments per discharge from RY 2010 to FY 2011, on average, for all LTCHs, while the proposed changes to the area wage adjustment are projected to result in an increase in estimated payments of 0.1 percent, on average, for all LTCHs.

As discussed in section V.B. of the Addendum to this proposed rule, we are proposing to update the wage index values for FY 2011 based on the most recent available data. In addition, we are proposing to decrease the labor-related share slightly from 75.779 percent to 75.407 percent under the LTCH PPS for FY 2011 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the RPL market basket (discussed in section VII.C.2. of the preamble of this proposed rule). This proposed update to the wage data and the labor-related share is expected to increase LTCH PPS payments by 0.1 percent.

Table IV below shows the impact of the proposed payment rate and proposed policy changes on LTCH PPS payments for FY 2011 by comparing RY 2010 estimated payments to FY 2011 estimated payments. The projected increase in payments per discharge from RY 2010 to FY 2011 is 0.8 percent (shown in Column 8). This projected increase in payments is attributable to the impacts of the proposed change to the standard Federal rate (−0.1 percent in Column 6) and the proposed change due to the area wage adjustment (0.1 percent in Column 7), as well as the effect of the estimated increase in payments for HCO cases and SSO cases in FY 2011 as compared to RY 2010 (0.5 percent and 0.3 percent, respectively). That is, estimated total HCO payments are projected to increase from RY 2010 to FY 2011 in order to ensure that estimated HCO payments will be 8 percent of total estimated LTCH PPS payments in FY 2011. An analysis of the most recent available LTCH PPS claims data (FY 2009 claims from the December 2009 update of the MedPAR files) indicates that the RY 2010 HCO threshold of $18,425 may result in HCO payments in RY 2010 that fall below the estimated 8 percent. Specifically, we currently estimate that HCO payments will be approximately 7.5 percent of estimated total LTCH PPS payments in RY 2010. We estimate that the impact of the increase in HCO payments would result in approximately a 0.5 percent increase in estimated payments from RY 2010 to FY 2011 on average for all LTCHs. Furthermore, in calculating the estimated increase in payments from RY 2010 to FY 2011 for HCO and SSO cases, we increased estimated costs by the applicable market basket percentage increase as projected by our actuaries, which increases payments by 0.3 percent relative to last year. We note that estimated payments for all SSO cases comprise approximately 14 percent of estimated total LTCH PPS payments, and estimated payments for HCO cases comprise approximately 8 percent of estimated total LTCH PPS payments. Payments for HCO cases are based on 80 percent of the estimated cost above the HCO threshold, while the majority of the payments for SSO cases (over 65 percent) are based on the estimated cost of the SSO case.

As we discuss in detail throughout this proposed rule, based on the most recent available data, we believe that the provisions of this proposed rule relating to the LTCH PPS will result in an increase in estimated aggregate LTCH PPS payments and that the resulting LTCH PPS payment amounts result in appropriate Medicare payments.

B. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table IV, we are projecting a 1.4 percent increase in estimated payments per discharge for FY 2011 as compared to RY 2010 for rural LTCHs that would result from the proposed changes presented in this proposed rule (that is, the proposed update to the standard Federal rate discussed in section V.A. of the Addendum to this proposed rule and the proposed changes to the area wage adjustment as discussed in section V.B. of the Addendum to this proposed rule) as well as the effect of estimated changes to HCO and SSO payments. This estimated impact is based on the data for the 26 rural LTCHs in our database of 421 LTCHs, for which complete data were available.

The estimated increase in LTCH PPS payments from RY 2010 to FY 2011 for rural LTCHs is primarily due to the higher than average impacts from the proposed changes to the area wage adjustment and the proposed reduction in the labor-related share from 75.779 to 75.407 percent, which results in an estimated 0.6 percent increase in payments. We believe that the proposed changes to the area wage adjustment presented in this proposed rule (that is, the proposed use of updated wage data and the proposed change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in FY 2011 because they are based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and appropriately identifies the portion of the standard Federal rate that should be adjusted to account for such differences in area wages, thereby resulting in accurate and appropriate LTCH PPS payments.

C. Anticipated Effects of Proposed LTCH PPS Payment Rate Change and Policy Changes

We discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011 (in terms of their estimated fiscal impact on the Medicare budget and on LTCHs) in section VII. of the preamble of this proposed rule.

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for

LTCHs "maintain budget neutrality." We believe that the statute's mandate for budget neutrality applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS were estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented.

As discussed in section IX.A. of this Appendix A, we project an increase in aggregate LTCH PPS payments in FY 2011 of approximately $41 million (or 0.8 percent) based on the 421 LTCHs in our database.

2. Impact on Providers

The basic methodology for determining a per discharge LTCH PPS payment is set forth in § 412.515 through § 412.536. In addition to the basic MS–LTC–DRG payment (standard Federal rate multiplied by the MS–LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO payments for those cases that qualify based on the threshold established each year.

To understand the impact of the proposed changes to the LTCH PPS payments presented in this proposed rule on different categories of LTCHs for FY 2011, it is necessary to estimate payments per discharge for RY 2010 using the rates and factors, including the FY 2010 GROUPER (Version 27.0) and relative weights, and policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030). It is also necessary to estimate the payments per discharge that would be made under the proposed LTCH PPS rates, factors, policies, and GROUPER (Version 28.0) for FY 2011 (as discussed in VII. of the preamble and section V. of the Addendum to this proposed rule). These estimates of RY 2010 and FY 2011 LTCH PPS payments are based on the best available LTCH claims data and other factors, such as the application of inflation factors to estimate costs for SSO and HCO cases in each year. We also evaluated the change in estimated RY 2010 payments to estimated FY 2011 payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2006 through FY 2007 cost report data in HCRIS, and PSF data. Hospitals with incomplete characteristics were grouped into the "unknown" category. Hospital groups include the following:

- Location: large urban/other urban/rural.
- Participation date.
- Ownership control.
- Census region.
- Bed size.

To estimate the impacts of the payment rates and policy changes among the various categories of existing providers, we used LTCH cases from the FY 2009 MedPAR file to estimate payments for RY 2010 and to estimate payments for FY 2011 for 421 LTCHs. We believe that the discharges based on the FY 2009 MedPAR data for the 421 LTCHs in our database, which includes 301 proprietary LTCHs, provide sufficient representation in the MS–LTC–DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients' diagnoses.

3. Calculation of Prospective Payments

For purposes of this impact analysis, to estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis using LTCH claims from the FY 2009 MedPAR files. For modeling estimated LTCH PPS payments for RY 2010, we applied the RY 2010 standard Federal rate (that is, $39,896.65, which is effective for LTCH discharges occurring on or after October 1, 2009, and through September 30, 2010). For modeling estimated LTCH PPS payments for FY 2011, we applied the proposed FY 2011 standard Federal rate of $39,856.75, which would be effective for LTCH discharges occurring on or after October 1, 2010, and through September 30, 2011.

Furthermore, in modeling estimated LTCH PPS payments for both RY 2010 and FY 2011 in this impact analysis, we applied the RY 2010 and proposed FY 2011 adjustments for area wage differences and the COLA for Alaska and Hawaii. Specifically, we adjusted for area wage differences for estimated RY 2010 payments using the RY 2010 LTCH PPS labor-related share of 75.779 percent (74 FR 43968), the wage index values established in the Tables 12A and 12B of the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44192 through 44213) and the RY 2010 COLA factors shown in the table in section V. of the Addendum to that final rule (74 FR 44026). Similarly, we adjusted for area wage differences for estimated FY 2011 payments using the proposed LTCH PPS FY 2011 labor-related share of 75.407 percent (section VII.C.2.d. of the preamble of this proposed rule), the FY 2011 proposed wage index values presented in Tables 12A and 12B of the Addendum to this proposed rule, and the FY 2011 COLA factors shown in the table in section V.B.5. of the Addendum to this proposed rule.

As discussed above, our impact analysis reflects an estimated change in payments for SSO cases as well as an estimated increase in payments for HCO cases (as described in section V.C. of the Addendum to this proposed rule). In modeling proposed payments for SSO and HCO cases in RY 2010, we applied an inflation factor of 1.024 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2009 MedPAR files and the best available CCRs from the December 2009 update of the PSF. In modeling proposed payments for SSO and HCO cases in FY 2011, we applied an inflation factor of 1.049 (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2009 MedPAR files and the best available CCRs from the December 2009 update of the PSF. Furthermore, in modeling estimated LTCH PPS payments for both RY 2010 and FY 2011 in this impact analysis, we applied the RY 2010 HCO fixed-loss amount of $18,425 (74 FR 44029) and the proposed FY 2011 fixed loss amount of $18,692 (as discussed in section V.C.3. of the Addendum of this proposed rule).

These impacts reflect the estimated "losses" or "gains" among the various classifications of LTCHs from the RY 2010 to FY 2011 based on the proposed payment rates and policy changes presented in this proposed rule. Table IV illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for RY 2010 (as described above).
- The fifth column shows the estimated payment per discharge for FY 2011 (as described above).
- The sixth column shows the percentage change in estimated payments per discharge from RY 2010 to FY 2011 for proposed changes to the standard Federal rate (as discussed in section V.A. of the Addendum to this proposed rule).
- The seventh column shows the percentage change in estimated

payments per discharge from RY 2010 to FY 2011 for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section V.B. of the Addendum to this proposed rule).

• The eighth column shows the percentage change in estimated payments per discharge from RY 2010 (Column 4) to FY 2011 (Column 5) for all proposed changes (and includes the effect of estimated changes to HCO and SSO payments).

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TABLE IV: Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for FY 2011 (Estimated FY 2010 Payments Compared to Estimated FY 2011 Payments*)

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2010 LTCH PPS Rate Year Payment Per Case[1] (4)	Average FY 2011 LTCH PPS Rate Year Proposed Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Proposed Changes[5] (8)
ALL PROVIDERS	421	131,490	37,304	37,616	-0.1	0.1	0.8
BY LOCATION:							
RURAL	26	5,610	31,693	32,125	-0.1	0.6	1.4
URBAN	395	125,880	37,554	37,860	-0.1	0.1	0.8
LARGE	204	75,855	39,025	39,364	-0.1	0.1	0.9
OTHER	191	50,025	35,324	35,580	-0.1	0.1	0.7
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,244	32,058	32,423	-0.1	0.2	1.1
OCT. 1983 - SEPT. 1993	44	16,824	38,212	38,574	-0.1	0.1	0.9
OCT. 1993 - SEPT. 2002	189	63,987	36,781	37,053	-0.1	0.1	0.7
AFTER OCTOBER 2002	161	41,657	38,501	38,831	-0.1	0.1	0.9
UNKNOWN PARTICIPATION DATE	10	2,778	37,710	38,233	-0.1	0.3	1.4
BY OWNERSHIP TYPE:							
VOLUNTAFY	77	19,922	37,393	37,822	-0.1	0.2	1.1
PROPRIETARY	301	105,986	37,212	37,492	-0.1	0.1	0.8
GOVERNMENT	12	1,588	38,960	39,458	-0.1	-0.2	1.3
UNKNOWN OWNERSHIP TYPE	31	3,994	38,639	39,134	-0.1	0.1	1.3
BY REGION:							
NEW ENGLAND	15	7,584	32,848	33,213	-0.1	0.1	1.1
MIDDLE ATLANTIC	29	7,742	38,086	38,320	-0.1	-0.2	0.6
SOUTH ATLANTIC	55	14,665	40,522	40,765	-0.1	-0.2	0.6
EAST NORTH CENTRAL	68	19,194	40,304	40,652	-0.1	0.2	0.9
EAST SOUTH CENTRAL	31	7,909	37,380	37,569	-0.1	-0.2	0.5
WEST NORTH CENTRAL	24	5,178	38,607	38,834	-0.1	0.0	0.6
WEST SOUTH CENTRAL	142	50,537	32,924	33,239	-0.1	0.3	1
MOUNTAIN	32	6,268	40,358	40,725	-0.1	0.0	0.9
PACIFIC	25	12,413	46,801	47,221	-0.1	0.3	0.9
BY BED SIZE:							

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2010 LTCH PPS Rate Year Payment Per Case[1] (4)	Average FY 2011 LTCH PPS Rate Year Proposed Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Federal Rate [3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Proposed Changes[5] (8)
BEDS: 0-24	42	5,288	32,969	33,438	-0.1	0.6	1.4
BEDS: 25-49	192	41,372	37,081	37,298	-0.1	0.0	0.6
BEDS: 50-74	101	32,024	38,230	38,567	-0.1	0.1	0.9
BEDS: 75-124	50	22,652	39,512	39,955	-0.1	0.3	1.1
BEDS: 125-199	21	15,145	35,296	35,660	-0.1	0.2	1
BEDS: 200 +	15	15,009	36,168	36,378	-0.1	0.0	0.6

[1] Estimated RY 2010 payments based on the rates, factors, including the FY 2010 GROUPER (Version 27.0) and relative weights, and policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030).
[2] Estimated FY 2011 LTCH PPS payments based on the proposed payment rates and policy changes presented in the preamble and the Addendum of this proposed rule.
[3] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for the proposed changes to the standard Federal rate, as discussed in section V.A. of the Addendum to this proposed rule.
[4] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for proposed changes to the area wage adjustment at §412.525(c) (as discussed in section V.B. of the Addendum to this proposed rule).
[5] Percent change in estimated payments per discharge from RY 2010 LTCH PPS (shown in Column 4) to FY 2011 LTCH PPS (shown in Column 5), including all of the proposed changes presented in the preamble of this proposed rule. Note, this column, which shows the percent change in estimated payments per discharge for all proposed changes, does not equal the sum of the percent changes in estimated payments per discharge for proposed changes to the standard Federal rate (column 6) and the proposed changes to the area wage adjustment (Column 7) due to the effect of estimated changes in both estimated payments to SSO cases that are paid based on estimated costs and aggregate HCO payments (as discussed in this impact analysis), as well as other interactive effects that cannot be isolated.

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4. Results

Based on the most recent available data (as described previously for 421 LTCHs, we have prepared the following summary of the impact (as shown in Table IV) of the proposed LTCH PPS payment rate and policy changes presented in this proposed rule. The impact analysis in Table IV shows that estimated payments per discharge are expected to increase approximately 0.8 percent, on average, for all LTCHs from RY 2010 to FY 2011 as a result of the proposed payment rate and policy changes presented in this proposed rule, as well as estimated increases in HCO and SSO payments. We note that we are proposing a −0.1 percent decrease to the standard Federal rate for FY 2011, based on the latest market basket estimate (2.4 percent) and the adjustment for the cumulative effect of changes in documentation and coding in FYs 2008 and 2009 (−2.5 percent). We noted earlier in this section that for most categories of LTCHs, as shown in Table IV (Column 6), the impact of the proposed decrease of −0.1 percent to the standard Federal rate is projected to result in approximately a −0.1 percent decrease in estimated payments per discharge for all LTCHs from RY 2010 to FY 2011. Furthermore, as discussed previously in this regulatory impact analysis, the average increase in estimated payments per discharge from the RY 2010 to FY 2011 for all LTCHs of approximately 0.8 percent (as shown in Table IV) was determined by comparing estimated FY 2011 LTCH PPS payments (using the proposed rates and policies discussed in this proposed rule) to estimated RY 2010 LTCH PPS payments (as described above in section IX.C. of this Appendix A).

a. Location

Based on the most recent available data, the vast majority of LTCHs are located in urban areas. Only approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 4 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table IV shows that the average percent increase in estimated payments per discharge from RY 2010 to FY 2011 for all hospitals is 0.8 percent for all proposed changes. For rural LTCHs, the percent change for all proposed changes is estimated to be 1.4 percent, while for urban LTCHs, we estimate the increase to be 0.8 percent. Large urban LTCHs are projected to experience an increase of 0.9 percent in estimated payments per discharge from RY 2010 to FY 2011, while other urban LTCHs are projected to experience an increase of 0.7 percent in estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV.

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 49 percent) of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience nearly the average increase (0.7 percent) in estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV.

In the participation category where LTCHs began participating in Medicare before October 1983, LTCHs are projected to experience a higher than average percent increase (1.1 percent) in

estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV. Approximately 4 percent of LTCHs began participating in Medicare before October 1983. The LTCHs in this category are projected to experience a higher than average increase in estimated payments because of estimated increases in payments due to the proposed change to the area wage adjustment, the proposed changes in the MS–LTC–DRG classifications and relative weights, and also because of estimated increases in their SSO payments relative to last year. Approximately 10 percent of LTCHs began participating in Medicare between October 1983 and September 1993. These LTCHs are projected to experience a slightly above average increase (0.9 percent) in estimated payments from RY 2010 to FY 2011. LTCHs that began participating in Medicare after October 2002 currently represent approximately 38 percent of all LTCHs, and are projected to experience a slightly above average increase (0.9 percent) in estimated payments from RY 2010 to FY 2011.

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: voluntary, proprietary, and government. Based on the most recent available data, approximately 18 percent of LTCHs are identified as voluntary (Table IV). We expect that, for these LTCHs in the voluntary category, estimated FY 2011 LTCH payments per discharge will increase higher than the average (1.1 percent) in comparison to estimated payments in RY 2010 primarily because we project an increase in estimated HCO payments and SSO payments to be higher than the average for these LTCHs. The majority (71 percent) of LTCHs are identified as proprietary and these LTCHs are projected to experience an average increase (0.8 percent) in estimated payments per discharge from RY 2010 to FY 2011. Finally, government-owned and operated LTCHs (3 percent) are expected to experience a higher than the average increase (1.3 percent) in estimated payments primarily due to a larger than the average increase in estimated HCO payments and increases under the proposed MS–LTC–DRG GROUPER (Version 28) and relative weights.

d. Census Region

Estimated payments per discharge for FY 2011 are projected to increase for LTCHs located in all regions in comparison to RY 2010. Of the 9 census regions, we project that the increase in estimated payments per discharge will have the largest positive impact on LTCHs in the New England and West South Central regions (1.1 percent, 1.0, respectively, as shown in Table IV). The estimated percent increase in payments per discharge from RY 2010 to FY 2011 for New England is largely attributable to the projected increase in estimated HCO and SSO payments (explained in greater detail above in section XV.B.4. of this Appendix A). The projected increase in estimated payments per discharge from RY 2010 to FY 2011 for LTCHs in the West South Central region is mostly due to the 43 percent of providers in this region that would receive a higher wage index in FY 2011 compared to RY 2010 and because all the providers have a proposed FY 2011 wage index less than 1, which results in an estimated payment increase because the proposed labor-related share (the portion of the rate adjusted by the wage index) is being reduced so their lower wage index adjusts a smaller portion of the rate.

In contrast, LTCHs located in the East South Central region are projected to experience a lower than average increase in estimated payments per discharge from RY 2010 to FY 2011. The less than average estimated increase in payments of 0.5 percent for LTCHs in the East South Central region is primarily due to estimated decreases in payments associated with the proposed wage index because 50 percent of LTCHs located in this region will have a proposed FY 2011 wage index value that is less than their RY 2010 wage index value. Similarly, LTCHs in the Middle Atlantic and South Atlantic are expected to experience a below average increase in payments of 0.6 percent primarily due to an estimated decrease in payment because of the proposed FY 2011 wage index changes.

e. Bed Size

LTCHs were grouped into six categories based on bed size: 0–24 beds; 25–49 beds; 50–74 beds; 75–124 beds; 125–199 beds; and greater than 200 beds.

We project that payments for small LTCHs (0–24 beds) will experience a 1.4 percent increase in payments due to increases in their wage index while large LTCHs (200+ beds) will experience smaller than average increase in payments of 0.6 percent. LTCHs with between 75 and 124 beds and between 125 and 199 beds are expected to experience an above average increase in payments per discharge from RY 2010 to FY 2011 (1.1 percent and 1.0 percent, respectively) primarily due to a larger than average estimated increase in payments from the proposed FY 2011 changes to the area wage adjustment.

D. Effect on the Medicare Program

As noted previously, we project that the provisions of this proposed rule will result in an increase in estimated aggregate LTCH PPS payments in FY 2011 of approximately $41 million (or about 0.8 percent) for the 421 LTCHs in our database.

E. Effect on Medicare Beneficiaries

Under the LTCH PPS, hospitals receive payment based on the average resources consumed by patients for each diagnosis. We do not expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS, but we expect that paying prospectively for LTCH services would enhance the efficiency of the Medicare program.

X. Effects of Proposed Policy Changes Regarding Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals Under Age 21

In section X. of the preamble of this proposed rule, we discuss our proposal to remove the Medicaid requirement for Joint Commission accreditation of psychiatric hospitals, hospitals with inpatient psychiatric programs, and PRTFs. Psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60, or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. In addition, PRTFs would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State. This proposal would remove specific references to national accrediting bodies to provide appropriate administrative flexibility to account for any changes in qualifying accrediting organizations.

Ensuring access to services is a priority for CMS, and we believe that this proposal would result in psychiatric hospitals, hospitals with

inpatient psychiatric programs, and PRTFs meeting comparable standards required in order to provide services. In addition, the proposed revision to the accreditation requirement aligns Medicaid standards with existing standards in the Medicare program. We believe that this flexibility in obtaining accreditation will facilitate the provision of medically necessary, Medicaid-reimbursable psychiatric services to vulnerable children, while maintaining the high quality of care demanded by the Medicaid program.

We are not preparing an analysis for this proposal under the RFA because we have determined that the proposal would not have a significant economic impact on a substantial number of small entities.

We are not preparing an analysis for section 1102(b) of the Act because this proposal would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This proposal would not result in an impact of $135 million or more on State, local or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this proposal does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

XI. Alternatives Considered

This proposed rule contains a range of policies. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies implementing policies where discretion has been exercised, and presents rationales for our decisions and, where relevant, alternatives that were considered.

XII. Overall Conclusion

A. Acute Care Hospitals

Table I of section VI. of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for the proposed MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall decrease of 0.1 percent in operating payments. We estimate that operating payments will decrease by approximately $142 million in FY 2011. In addition, this estimate includes the reporting of hospital quality data program costs of $2.4 million, and a savings of $21 million associated with the proposed HACs policies and all other proposed operating payment policies described in section VII. of this Appendix. We estimate that capital payments will experience −0.2 percent change in payments per case, as shown in Table III of section VIII. of this Appendix. We estimate that capital payments will decrease by approximately $20 million in FY 2011 compared to FY 2010. The proposed cumulative operating and capital payments should result in a net decrease of $181 million to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this proposed rule, constitute a regulatory impact analysis.

B. LTCHs

Overall, LTCHs are projected to experience an increase in estimated payments per discharge in FY 2011. In the impact analysis, we are using the proposed rates, factors, and policies presented in this proposed rule, including proposed updated wage index values and relative weights, and the best available claims and CCR data to estimate the change in payments under the LTCH PPS for FY 2011. Accordingly, based on the best available data for the 421 LTCHs in our database, we estimate that FY 2011 LTCH PPS payments will increase approximately $41 million (or about 0.8 percent).

XIII. Accounting Statements

A. Acute Care Hospitals

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table V below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the proposed changes to the IPPS presented in this proposed rule. All expenditures are classified as transfers to Medicare providers.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2010 TO FY 2011

Category	Transfers
Annualized Monetized Transfers.	−$181 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	−$181 million.

B. LTCHs

As discussed in section IX. of this Appendix, the impact analysis for the proposed changes under the LTCH PPS for this proposed rule projects an increase in estimated aggregate payments of approximately $41 million (or about 0.8 percent) for the 421 LTCHs in our database that are subject to payment under the LTCH PPS. Therefore, as required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table VI below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to changes to the LTCH PPS. Table VI provides our best estimate of the proposed increase in Medicare payments under the LTCH PPS as a result of the proposed provisions presented in this proposed rule based on the data for the 421 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE VI—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM THE 2010 LTCH PPS RATE YEAR TO THE FY 2011 LTCH PPS

Category	Transfers
Annualized Monetized Transfers.	Positive transfer—Estimated increase in expenditures: $41 million.
From Whom to Whom	Federal Government to LTCH PPS Medicare Providers.
Total	$41 million.

XIV. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Executive Office of Management and Budget reviewed this proposed rule.

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for certain hospitals excluded from the IPPS, as well as LTCHs, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2011

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and LTCH PPS.

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Public Law 109–171, sets the FY 2011 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points.

Consistent with current law, based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter, of the FY 2011 IPPS market basket increase, we are estimating that the FY 2011 update to the standardized amount will be 2.4 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we are estimating that the update to the standardized amount will be 0.4 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2011, we are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.4 percent.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2011 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is estimated to be 2.4 or 0.4 percent, depending upon whether the hospital submits quality data.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. In addition, section 124 of Public Law 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are proposing to provide our current estimate of the FY 2011 IPPS operating market basket percentage increase (2.4 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

For FY 2011, as discussed in section VII. of the preamble to this proposed rule, we are proposing an update of −0.1 percent to the LTCH PPS standard Federal rate, which is based on a proposed market basket increase of 2.4 percent (based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket increase for FY 2011) and an adjustment of −2.5 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721).

III. Secretary's Recommendations

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2011. MedPAC's rationale for this update recommendation is described in more detail below. As mentioned above, section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically

appropriate and necessary care of high quality. Consistent with the update factor in the President's budget, we are recommending an update to the standardized amount of 2.9 percent. We are recommending that this same update factor apply to SCHs and MDHs.

Section 1886(d)(9)(C)(i) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2011, we are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.4 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we also are recommending update factors for all other types of hospitals. Consistent with the update factor in the President's budget, we are recommending an update for children's hospitals, cancer hospitals, and RNHCIs of 2.9 percent.

For FY 2011, consistent with the proposal set forth in section VII. of the preamble of this proposed rule, we are recommending an update of −0.1 percent to the LTCH PPS standard Federal rate. In addition, based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the RPL market basket increase, we are recommending an update of 2.4 percent to the IRF PPS Federal rate for FY 2011 and an update of 2.4 percent to the IPF PPS Federal rate for RY 2011 for the Federal per diem payment amount.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its March 2010 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base. MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2011, concurrent with implementation of a quality incentive program. MedPAC's reasoning is that under a quality program, an individual hospital's quality performance should determine whether its net increase in payments is above or below the market basket increase. MedPAC noted the importance of hospitals to control their costs rather than accommodate the current rate of cost growth.

MedPAC also noted that indicators of payment adequacy are positive. MedPAC expects Medicare margins to remain low in 2011. At the same time though, MedPAC's analysis finds that high-performing hospitals have been able to maintain relatively low costs while maintaining a relatively high quality of care. In addition, roughly half of these providers are generating a profit on their Medicare business.

Response: Similar to our response last year, we agree with MedPAC that hospitals should control costs rather than have Medicare accommodate the current rate of growth. As MedPAC noted, the lack of financial pressure at certain hospitals can lead to higher costs and in turn bring down the overall Medicare margin for the industry.

In addition to the quality data that hospitals are required to submit to CMS, as discussed in section II. of the preamble of this proposed rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The proposed update to the capital rate is discussed in section III. of the Addendum to this proposed rule.

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