DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 415, 424, 440, 441, 482, 485, and 489

[CMS–1498–Fand CMS–1498–IFC; CMS–1406–F]

RIN 0938–AP80; RIN 0938–AP33

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services

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

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

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems and to implement certain provisions of the Affordable Care Act and other legislation. In addition, we describe the changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. We also are setting forth the update to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits.

We are updating the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and setting forth the changes to the payment rates, factors, and other payment rate policies under the LTCH PPS. In addition, we are finalizing the provisions of the August 27, 2009 interim final rule that implemented statutory provisions relating to payments to LTCHs and LTCH satellite facilities and increases in beds in existing LTCHs and LTCH satellite facilities under the LTCH PPS.

We are making changes affecting the: Medicare conditions of participation for hospitals relating to the types of practitioners who may provide rehabilitation services and respiratory care services; and determination of the effective date of provider agreements and supplier approvals under Medicare.

We are also setting forth provisions that offer psychiatric hospitals and hospitals with inpatient psychiatric programs increased flexibility in obtaining accreditation to participate in the Medicaid program. Psychiatric hospitals and hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey or of obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS.

We are also issuing an interim final rule with comment period to implement a provision of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 relating to Medicare payments for outpatient services provided prior to a Medicare beneficiary's inpatient admission.

DATES: *Effective Date:* These rules are effective on October 1, 2010, except for amendments to § 412.2(c)(5) introductory text, (c)(5)(iii), and (c)(5)(iv); § 412.405; § 412.521(b)(1); § 412.540; § 412.604(f); § 413.40(c)(2) introductory text, (c)(2)(iii), and (c)(2)(iv), that are effective on June 25, 2010 and apply to services furnished on or after June 25, 2010. In accordance with sections 1871(e)(1)(A)(i) and (ii) of the Social Security Act, the Secretary has determined that retroactive application of these regulatory amendments is necessary to comply with the statute and that failure to apply the changes retroactively would be contrary to public interest:

Comment Period: To be assured consideration, comments on the interim final rule with comment period (CMS–1498–IFC) that appears as section IV.M., of the preamble of this document and includes amendments to § 412.2(c)(5) introductory text, (c)(5)(iii), and (c)(5)(iv); § 412.405; § 412.521(b)(1); § 412.540; § 412.604(f); § 413.40(c)(2) introductory text, (c)(2)(iii), and (c)(2)(iv) must be received at one of the addresses provided below, no later than 5 p.m. EST on September 28, 2010. Comments on other sections of this document will not be considered.

ADDRESSES: When commenting on issues presented in the interim final rule with comment period, please refer to file code CMS–1498–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1498–IFC, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1406–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Operating Prospective Payment, MS–DRGs, 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, Public Law 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, Public Law 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
HICANHealth Insurance Claims Account Number
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HPMP Hospital Payment Monitoring Program
HSA Health savings account
HSCRC [Maryland] Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative

HwH Hospital-within-a-hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
ICR Information collection requirement
IHS Indian Health Service
IME Indirect medical education
I–O Input-Output
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS [Acute care hospital] inpatient prospective payment system
IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LOS Length of stay
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MRSA Methicillin-resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NALTH National Association of Long Term Hospitals
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
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, Public Law 99–509
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
OPM U.S. Office of Personnel Management
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
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, Public Law 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, Public Law 97–248
TEP Technical expert panel
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Public Law 110–90
UHDDS Uniform hospital discharge data set

Table of Contents

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, 2012, 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) and 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 Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148 and certain sections of the Social Security Act, and, in certain instances, included certain "freestanding" provisions that affect implementation of the IPPS and the LTCH PPS. (Pub. L. 111–148 and Pub. L. 111–152 are collectively referred to as the "Affordable Care Act.") A number of the provisions of the Affordable Care Act affected the updates to the IPPS and the LTCH PPS and the providers and suppliers that were addressed in the FY 2011 IPPS/LTCH PPS proposed rule that appeared in the **Federal Register** on May 4, 2010 (75 FR 23852). However, due to the timing of the passage of the legislation, we were unable to address those provisions in the May 4, 2010 proposed rule. Therefore, on June 2, 2010, we issued in the **Federal Register** two additional documents:

1. A supplemental proposed rule (75 FR 30918) to the FY 2010 IPPS/LTCH PPS proposed rule published on May 4, 2010, that proposed to implement certain provisions of the Affordable Care Act. These proposed provisions are outlined in section I.D.2. of this final rule, and are being finalized in the appropriate subject-matter sections of this final rule.

2. A notice (75 FR 31118) that contained the final wage indices, hospital reclassifications, payment rates, impacts, and other related tables, effective for the FY 2010 IPPS and the RY 2010 LTCH PPS, that were required by or directly resulted from implementation of provisions of the Affordable Care Act.

C. Provisions of the Preservation of Access To Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111–192)

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111–192) was enacted. Section 102 of Public Law 111–192 amended section 1886(a)(4) and (d)(7) of the Act affecting Medicare payments for preadmission services furnished to outpatients who are later admitted as inpatients during a specified payment window. We are implementing this legislative provision as discussed under section IV.M. of the preamble of this document through an interim final rule with comment period.

D. Issuance of Two Notices of Proposed Rulemaking for FY 2011

1. Issuance of May 4, 2010 IPPS/LTCH PPS Proposed Rule

On May 4, 2010, we issued in the **Federal Register** the FY 2011 IPPS/LLTCH PPS proposed rule (75 FR 23852). In that proposed rule, we set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2011. We also set forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis.

In addition, in that proposed rule, we set 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 now takes place on the same schedule and in the same publication as for the IPPS, for the sake of clarity, in section VII.D. of the proposed rule, we proposed 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 the proposed rule (and this final rule), we use the phrase "fiscal year (FY)" in referring to updates and changes to the LTCH PPS.

Below is a summary of the major changes that we proposed to make in the May 4, 2010 proposed rule:

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

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

- Proposed changes to MS–DRG classifications based on our yearly review.
- Proposed application of the documentation and coding adjustment 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 discussed 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).

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

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

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

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

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- 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.

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

In section V. of the preamble to the 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.

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

In section VI. of the preamble of the 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.

f. Proposed Changes to the LTCH PPS

In section VII. of the preamble of the proposed rule, we set forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for 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 documentation and coding adjustment under the LTCH PPS for FY 2011.

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

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

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

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

i. 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 the proposed rule, we proposed 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. (We note that we proposed a similar change for psychiatric rehabilitation treatment facilities, which we are not adopting in this final rule.)

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

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

k. Determining Proposed Prospective Payment Rates for LTCHs

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2011 prospective standard Federal rate. We also proposed to establish the proposed adjustments for wage levels, the labor-related share, the cost-of-living adjustment, and high-cost outliers, including the fixed-loss

amount, and the LTCH cost-to-charge ratios (CCRs) under the LTCH PPS.

l. Impact Analysis

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

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

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

n. 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 addressed these recommendations in Appendix B of the proposed rule. For further information relating specifically to the MedPAC March 2008 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov.*

2. Issuance of June 2, 2010 Proposed Rule

A number of the provisions of the Affordable Care Act affected the IPPS and the LTCH PPS and the applicable providers and suppliers. Due to the timing of the passage of the legislation, we were unable to address these provisions in the FY 2011 IPPS/LTCH PPS proposed rule that appeared in the May 4, 2010 **Federal Register** (75 FR 23852). Therefore, various proposed policies and payment rates in that proposed rule did not reflect the new legislation. We noted in that proposed rule that we would issue separate **Federal Register** documents addressing the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2010 and FY 2011 under the IPPS and for RY 2010 and FY 2011 under the LTCH PPS.

On June 2, 2010, we issued a supplemental proposed rule in the **Federal Register** (75 FR 30918) that addressed the following FY 2011 policies and provisions of the Affordable Care Act:

- Hospital wage index improvement related to geographic reclassification criteria for FY 2011 (section 3137 of Pub. L. 111–148).
- National budget neutrality in the calculation of the rural floor for hospital wage index (section 3141 of Pub. L. 111–148).
- Protections for frontier States (section 10324 of Pub. L. 111–148).
- Revisions of certain market basket updates (sections 3401 and 10319 of Pub. L. 111–148 and section 1105 of Pub. L. 111–152).
- Temporary improvements to the low-volume hospital adjustment (sections 3125 and 10314 of Pub. L. 111–148).
- Extension of Medicare-dependent hospitals (MDHs) (section 3124 of Pub. L. 111–148).
- Additional payments in FYs 2011 and 2012 for qualifying hospitals in the lowest quartile of per capital Medicare spending (section 1109 of Pub. L. 111–152).
- Extension of the rural community hospital demonstration (sections 3123 and 10313 of Pub. L. 111–148).
- Technical correction related to CAH services (section 3128 of Pub. L. 111–148).
- Extension of certain payment rules for LTCH services and of moratorium on the establishment of certain hospitals and facilities and increases in beds in existing LTCHs or LTCH satellite facilities (sections 3106 and 10312 of Pub. L. 111–148).

We also noted that we planned to issue further instructions implementing the provisions of the Affordable Care Act that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS in a separate document published elsewhere in June 2, 2010 **Federal Register**.

In this final rule, we are finalizing both the provisions of the May 4, 2010 proposed rule and the June 2, 2010 supplemental proposed rule in one document.

E. Public Comments Received on the FY 2011 IPPS/LTCH PPS Proposed Rule and Supplemental Proposed Rule

We received over 700 public comments on the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule and approximately 33 public comments on the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule. One comment addressed the comment period for the supplemental proposed rule.

Comment: One commenter objected to our decision to shorten the usual 60-day comment period for the supplemental proposed rule. The commenter did not believe that CMS had the authority to shorten the comment period and stated that the period allowed for comment on the policies in the supplemental proposed rule was insufficient.

Response: We disagree with the commenter that the waiver of the full 60-day comment period in the supplemental proposed rule was insufficient. As we explained in the supplemental proposed rule, due to the timing of the enactment of the Affordable Care Act, the policies and payment rates outlined in the FY 2011 IPPS/LTCH proposed rule published in the **Federal Register** on May 4, 2010, did not reflect the changes made by that law to the IPPS and LTCH PPS. The supplemental proposed rule addressed the changes that affect our policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. We refer readers to the waiver of 60-day comment period discussion in the supplemental proposed rule (75 FR 30971), and we welcome the opportunity to provide additional details regarding our decision to waive the 60-day comment period.

Our decision to shorten the customary 60-day comment period is consistent with past agency practice (see, for example, 74 FR 26603 (June 3, 2009), 74 FR 43952 (August 27, 2009), and 68 FR 34772 (June 10, 2003)), as well as the language of section 1871(b)(2)(C) of the Act. We read section 1871(b)(2)(C) of the Act to permit a waiver of any or all of the procedures set forth in section 1871(b)(1) of the Act, including the 60-day comment period, if good cause exists.

We believe the commenter's description of the period allowed for comment overstated the inconvenience that the shortened comment period may have created. We believe that the detailed and thoughtful comments that we received in response to the contents of the supplemental proposed rule support our position that there was time for meaningful public participation in

the development of these policies. In addition, as the commenter admits, parties had 28 days from the posting of the supplemental proposed rule to submit comments to CMS, and a Listserv posting alerted outside parties to the posting of agency regulations.

The FY 2011 IPPS/LTCH PSS final rule must be effective as of October 1, 2010, the start of FY 2011. Given this statutory deadline, we believe it was necessary to shorten the time period, as permitted by section 1871(b)(2)(C) of the Act. As we explained in the waiver of 60-day comment period discussion in the supplemental proposed rule, unless we shortened the comment period, there would have been no opportunity for the agency to appropriately consider the comments we received and resolve whether any of the proposed policies would be modified in light of comments received. The comment period set forth in the supplemental proposed rule provided the agency with the minimum time needed for a careful consideration of the public comments on both the FY 2011 IPPS/LTCH PPS final rules. Moreover, a full 60-day comment period from the date of publication in the **Federal Register**, which is what the comment period would be if the commenter's reading of section 1871(b)(2)(C) of the Act were adopted by the agency, would have extended into August, which would have been impracticable, given the required effective date of October 1, 2010.

The remaining public comments we received on the two proposed rules addressed issues on multiple topics in both of the proposed rules. We present a summary of the public comments and our responses to them in the applicable subject-matter sections of this final rule.

F. Finalization of the 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, Pub. L. 111–5) included several amendments to section 114 of Public Law 110–173 (MMSEA) relating to payments to LTCHs and LTCH satellite facilities that 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. Sections 3106 and 10312 of the Affordable Care Act added an additional 2 years to the 3-year implementation delay established by section 114(c) and (d)(1) of MMSEA. These provisions of the Affordable Care Act applicable to the LTCH PPS were discussed in the June 2, 2010 supplemental proposed rule (75 FR 30967).

In section VII.E. of the preamble of this final rule, we respond to the public comment that we received in a timely manner on this interim final rule with comment period and finalize the interim final rule.

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

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, Medicare pays 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 final 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 final 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 ICD–10–PCS

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

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 were assigned to one of 746 MS–DRGs in 25 MDCs. For FY 2011, cases will be assigned to one of 747 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.

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 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 41499 and 41500), we discussed a process for considering non-MedPAR data in the recalibration process. We stated that for use of non-MedPAR data to be feasible for purposes of DRG recalibration and reclassification, the data must, among other things: (1) Be independently verified; (2) reflect a complete set of cases (or a representative sample of cases); and (3) enable us to calculate appropriate DRG relative weights and ensure that cases are classified to the "correct" DRG, and to one DRG only, in the recalibration process. Further, 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 non-MedPAR 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 2011 proposed rule was based on data from the September 2009 update of the FY 2009 MedPAR file, which contained hospital bills received through September 30, 2009, for discharges occurring through September 30, 2009. For this FY 2011 final rule, our MS–DRG analysis is based on data from the March 2010 update of the FY 2009 MedPAR file, which contained hospital bills received through March 31, 2010, 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 public commenters regarding the proposal to adopt CS DRGs. We acknowledged the many public 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 proposed and final actions 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 final rule.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY 2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost reports 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 the extent, if any, to which our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this final rule for a 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 making in this final 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. 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 MS–DRGs for FY 2010; there will be 747 MS–DRGs in FY 2011, with the deletion in this final rule of one MS–DRG and the creation of two new MS–DRGs.) By increasing the number of MS–DRGs and more fully taking into account patient 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 patient 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 our 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 care 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 the relative weights applicable for each year. The results ranged from −0.7 to +1.4 percent.

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 the years in the FY 2000 to FY 2007 time period was negative. For example, as discussed in that rule (74 FR 43769), we estimated a recent measurement effect of +0.3 percent. There was an overall case-mix growth of −0.2 percent in FY 2007. The overall case-mix growth of −0.2 percent net of a measurement effect of +0.3 percent results in growth of +0.1 percent. Had real case-mix growth been +1.2 percent in FY 2007, therefore, it would imply 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 average annual trend claimed by the commenters, calling into question the assertion that real case-mix growth is a steady 1.2 to 1.3 percent per year.

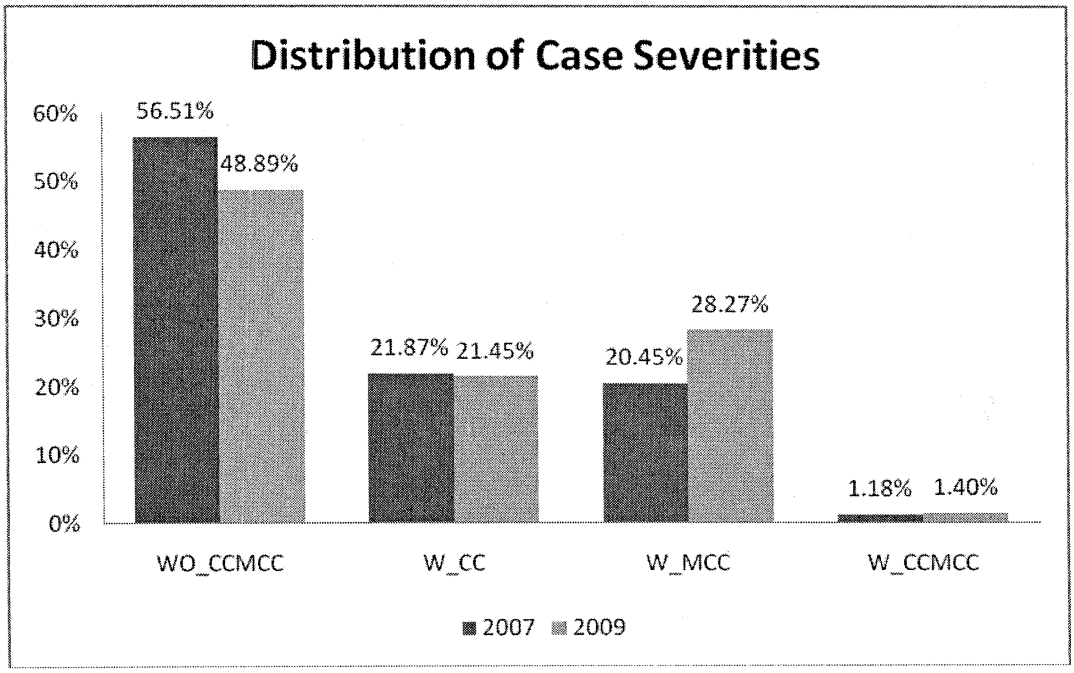
In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43770 through 43771), we indicated that our estimate of the overall case-mix growth for FY 2008 based on more recent data than the data used in the FY 2010 proposed rule was 2.0 percent, still less than our actuaries' estimate of a 2.5 percent documentation 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.

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 note that in the FY 2011 IPPS/LTCH PPS proposed rule, we performed this analysis using FY 2009 claims paid through December 2009. In this FY 2011 IPPS/LTCH PPS final rule, we have updated the analysis with FY 2009 claims paid through March 2010, as we discussed in the proposed rule. We note that, for non-Puerto Rico IPPS hospitals, the estimates are unchanged from those in the proposed 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 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.

In parallel to our analysis in the proposed rule, 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 approximately an 8 percentage point increase in the discharge severity with MCCs from 20 percent to 28 percent, and a corresponding decrease of approximately 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, hospitals are able to appropriately change the severity level of cases from the lowest level (non-CC) to a higher severity level (CC or MCC) through coding. This point was stressed repeatedly at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting as coders discussed their work with physicians on this coding issue. Many of the participants indicated that additional work was still needed with their physicians in order to document conditions in the medical record more precisely.

The results of this analysis 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 110–90, 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 and final rules 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 110–90. We had the statutory authority to adjust the FY 2010 rates for this estimated 1.4 percentage point increase. However, given that Public Law 110–90 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 then-estimated −6.6 percent adjustment to the standardized amount.

In the FY 2010 IPPS/RY 2010 LTCH PPS final 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 a prospective adjustment to eliminate the full effect of coding or classification changes that did not reflect real changes in case-mix for discharges occurring during FY 2008, we 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.

Therefore, 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 estimates at that time, 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 for this FY 2011 IPPS/LTCH PPS final rule, 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, in the FY 2011 proposed rule, we proposed an adjustment under that section for FY 2011 (75 FR 23870–23871). Therefore, we believe it is appropriate to not implement any or all of the −3.9 percent prospective adjustment in FY 2011. Accordingly, we did not propose a prospective adjustment under section 7(b)(1)(A) of Public Law 110–90 for FY 2011 (75 FR 23868–23870). 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. Our actuaries estimate that this 3.9 percentage point increase will result in an aggregate payment of approximately $4 billion. We also note that payments in FY 2010 are expected to 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, which our actuaries estimate will increase aggregate payments by approximately $4 billion in FY 2010.

In the FY 2011 IPPS/LTCH PPS proposed rule, we sought 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. As noted earlier, we have updated our analysis with FY 2009 data on claims paid through March 2010 for this FY 2011 IPPS/LTCH PPS final rule.

MedPAC addressed the issue of providing for the required −3.9 percent prospective adjustment to the average standardized amounts required under section 7(b)(1)(A) of Public Law 110–90. We discuss its recommendation in the context of our proposal for a recoupment adjustment below.

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. In the FY 2011 proposed rule (75 FR 23871), we stated that we intend to take into account the need to reflect accumulated interest in proposing a recoupment adjustment under section 7(b)(1)(B) of Public Law 110–90 for FY 2012. We indicated that we will invite public 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, in the FY 2011 proposed rule, we proposed 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 when necessary, we stated that we anticipated that the 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, we noted an advantage of the proposal for FY 2011 is that we anticipate removing the 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 noted this anticipated effect of the FY 2011 proposal, we did not make a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in the FY 2011 proposed rule.

In the FY 2011 IPPS/LTCH PPS proposed rule, we sought 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 noted that we intended to update our analysis with FY 2009 data on claims paid through March 2009 (sic) for this FY 2011 IPPS/LTCH PPS final rule. (We note that the March 2009 update date for claims data in the proposed rule should have been March 2010.) As intended, we have updated our analysis with FY 2009 data on claims paid through March 2010 in this FY 2011 IPPS/LTCH PPS final rule.

We received numerous comments on our proposal, especially from national and regional hospital associations, hospital systems, and individual hospitals. MedPAC also commented on our proposal.

Comment: One commenter requested that CMS refrain from using "negative terminology" to refer the documentation and coding improvement practices that, in response to the introduction of MS–DRGs, resulted in overall case-mix increase. While CMS frequently refers to implementing negative payment adjustments to account for this case-mix increase, the commenter requested that CMS we refer to any such adjustment as a "budget-neutrality adjustment." The commenter contended that referring to "overpayments" and "negative payment adjustments" inaccurately portrays coding professionals in a poor manner, and is counterproductive to CMS' goal of improving the quality and consistency of health care data.

Response: When describing the MS–DRG documentation and coding adjustment, we have not intended to suggest that these adjustments are necessary because coders have acted inappropriately, unethically, or otherwise in bad faith by employing documentation and coding improvement practices associated with the adoption of the MS–DRG system.

Under the previous DRG definitions, it was possible for high-severity cases not to be paid more than cases with lower severity. The MS–DRGs were introduced as part of the effort to ensure that the relative Medicare payment rates that hospitals received more reasonably matched the resources that hospitals expended in furnishing care, and CMS encouraged hospitals to code as accurately as possible with that goal in mind.

However, it is our finding that the systematic effect of changing documentation and coding in order to receive the fullest payment for providing care to beneficiaries under the MS–DRGs has led to an increase in aggregate payments that do not reflect real changes in case-mix severity, and the statute specifically requires that we adjust for and recover these associated overpayments due to such documentation and coding improvements. We believe our use of certain terminology (to which the commenter took exception) is the most accurate description of the specific statutorily required activities that CMS must pursue.

Comment: Numerous commenters detailed the potentially severe negative fiscal impact that would be experienced by providers if the proposed documentation and coding improvement adjustment were to be implemented. Many commenters contended that their individual hospital documentation and coding practices were not specifically changed or did not change at the levels shown by our analysis with the introduction of MS–DRGs, and that they would be unfairly penalized by the payment adjustment. Some of these commenters provided examples that they believed supported their claims. Another commenter requested that CMS implement a more refined payment adjustment methodology that would not penalize hospitals with compliant and ethical documentation and coding standards.

Response: We understand the concerns about possible financial disruption that may be caused by the proposed documentation and coding improvement payment adjustment. However, we are required by section 7(b)(1)(B) of Public Law 110–90 to implement the appropriate recoupment or repayment adjustment based on our analysis no later FY 2012. These payment adjustments are necessary to correct past overpayments due to increases in aggregate payments that do not reflect real changes in case-mix severity, but instead are caused solely by documentation and coding improvements. We proposed a phase-in implementation of the required adjustments to allow hospitals time to adjust to future payment differences and to moderate the effect of this adjustment in any given year. We do not believe that it would prudent to postpone making any recoupment adjustment beyond FY 2011. A postponement would require us to make the entire −5.8 percent adjustment that is warranted by our analysis in just one year (FY 2012) in order to meet the statutory requirement of section 7(b)(1)(B) of Public Law 110–90. Such a delay in making the required adjustment would not be to the financial benefit of hospitals.

Under Medicare's prospective payment systems, it is neither feasible nor possible to quantify any amount of case-mix increase due to documentation and coding improvements by a specific hospital. Therefore, it is necessary for CMS to propose a national adjustment to meet the statutory requirement of section 7(b)(1)(B) of Public Law 110–90 to calculate and recover any overpayments caused by documentation and coding improvements due to the introduction of the MS–DRG system.

Comment: In its public comment, MedPAC describes the history and nature of the documentation and coding adjustment. MedPAC stated that "CMS adopted the MS–DRGs to improve the distribution of payments." Specifically, it discussed how, under the DRG definitions used previously, high-severity cases may have been paid similarly to cases with low or moderate severity. MedPAC emphasized that "the shift to MS–DRGs was taken to improve the distribution of payments, not change the aggregate level of payments." Further, MedPAC described the financial incentive for hospitals to improve documentation and coding under the MS–DRG system, and also the statutory requirement for CMS to ensure that changes in the DRGs and relative weights do not increase or decrease aggregate IPPS payments absent those changes, noting that Public Law 110–90 provided for specific requirements related to payments for FYs 2008 and 2009. MedPAC pointed out that, as a result of these combined legal requirements, our proposals "do not represent payment cuts, but rather offset unintended overpayments to hospitals."

MedPAC performed an independent analysis of claims data to determine the effect of documentation and coding in FYs 2008 and 2009. MedPAC stated, "[i]n our judgment, CMS's analytic methods are valid. Using similar methods, our analysis of Medicare hospital inpatient claims for 2007–2009 confirms all of CMS's findings." (We note that, in line with our evaluation of claims data in for this final rule, MedPAC's retrospective evaluation of the same claims data yielded nearly identical results.)

MedPAC's analysis demonstrated that the cumulative effect of documentation and coding in FY 2009 was 5.4 percent and the cumulative overpayment in FY 2009 was 5.8 percent. Furthermore, because CMS has already implemented adjustments of −0.6 percent and −0.9 percent in FYs 2008 and 2009 respectively, MedPAC concurred that the necessary adjustment under section 7(b)(1)(B) of Public Law 110–90 requires CMS to prospectively reduce payment rates by −3.9 percent to prevent further increases in aggregate spending due to the change to MS–DRGs. (As we discuss elsewhere in this section, unlike the recoupment adjustment, the statute does not prescribe a specific timeframe within which we must implement the prospective adjustment.) In fact, MedPAC concluded, "CMS correctly estimated the effect of documentation and coding on case mix and patients."

However, while acknowledging the concerns we expressed in opting to phase in implementing the full retrospective adjustment (−5.8 percent) together with the prospective adjustment (−3.9 percent), noting that this combined adjustment of −9.7 percent "may be financially disruptive"), MedPAC expressed concerns that our proposal to adjust rates by −2.9 percent, which is half of the retrospective adjustment needed to address the cumulative overpayment in FY 2011, is insufficient to fully offset unintended overpayments to hospitals. Furthermore, MedPAC stated that such a delay in implementing offsets for the operating and capital IPPS will cause a progressive accumulation in overpayments, which cannot be recovered based upon current statutory authority. MedPAC stated plainly that "CMS will not achieve budget neutrality unless Congress directs it to recover all overpayments."

As such, MedPAC recommended, for both the operating and capital IPPS, that "overpayments should be stopped [and] all overpayment should be recovered." In making that recommendation, MedPAC directed CMS to its March 2010 Report to Congress where it recommended that Congress change the law to require CMS to recover all overpayments with interest. It noted that this would shift our focus to the prevention of future overpayments in the operating and capital IPPS. MedPAC further noted that such a shift might be implemented as prospective adjustments and would results in slower

accumulation of future overpayments. Specifically, it summarized its recommendations for both the operating and capital IPPS as:

- MedPAC's approach would reduce payments in increments of no more than 2 percent for 3 years.
- Hospitals would continue to receive their scheduled updates, which would offset much of their reduction.
- After 3 years, hospitals would receive their scheduled updates without any additional offsets.
- After roughly 6 years, overpayments would be fully recovered, and hospitals would see an increase in payments of roughly 2 percent in addition to their scheduled update.

In the absence of the changes in law that would permit such an approach, MedPAC provided an alternative multiyear approach in its public comments in response to our request for comments on our proposal to offset part of the cumulative overpayment in FY 2011 and our proposal not to apply the remaining prospective adjustment in FY 2011. MedPAC recommended that CMS recover the FY 2008 and 2009 overpayments as quickly as possible to mitigate the need for further and more drastic payment corrections. In FY 2012, MedPAC recommended completing the retrospective adjustment, with accumulated interest, to fulfill the requirements of section 7(b)(1)(B) of Public Law 110–90 and then making additional prospective adjustments in that year of −2.0 percent. The nature of the retrospective adjustment would moderate the impact of the total adjustment for FY 2012, and MedPAC estimated the net effect to be roughly 2.0 percent. (As we discuss below, one reason for the moderating effect of the recoupment adjustment is that it is only a 1-year adjustment, rather than a permanent and cumulative adjustment. As a result, the FY 2011 recoupment adjustment would be removed from the FY 2012 rate before any new adjustments are applied. For example, in FY 2012, the −2.9 percent adjustment from FY 2011 would be removed by adding 2.9 percent to the FY 2012 rate before making any additional adjustments through rulemaking.) In FY 2013, MedPAC recommended completing the prospective adjustment for increases that occurred in FYs 2008 and 2009, noting that, again, in FY 2013, the impact of the prospective adjustment would be moderated by the expiration of the retrospective adjustment in the prior year.

Response: We appreciate MedPAC's independent validation and support of our methodology. We note that MedPAC stated that its estimate for the cumulative documentation and coding effect for FYs 2008 and 2009 net of measurement error is 5.4 percent. This estimate was derived using the same data sources and analogous methodologies as the analysis set forth by CMS in this FY 2011 IPPS/LTCH–PPS final rule and matches the CMS estimate in the prior discussion.

Furthermore, we agree with MedPAC's conclusions on the overall financial implications of implementing our proposed −2.9 percent payment rate adjustment. We share MedPAC's concerns about delaying the prevention of future overpayments in both the capital and operating IPPS, but we appreciate its acknowledgment of CMS' discretion regarding the timing of implementation of the prospective adjustment and of the potential financial disruption from implementation of the full prospective reduction in FY 2011 (−3.9 percent) in addition to the proposed retroactive adjustment (−2.9 percent). We also appreciate MedPAC's concerns for prioritizing the recoupment of FYs 2008–2009 overpayments for the operating IPPS because CMS lacks the statutory authority to adjust for further accumulation of these overpayments beyond FY 2012. MedPAC appropriately pointed out the moderating effect of the multiyear approach to implementing the retroactive adjustment to recover overpayments in FYs 2008 and 2009. The expiration of these adjustments in the following year mitigates any negative adjustments made in that following year. We thank MedPAC for its specificity in setting forth an approach for completing the adjustments prescribed under sections 7(b) and (c) of Public Law 110–90 and will take these recommendations into consideration in future rulemaking. Finally, we concur with MedPAC's statement that these adjustments associated with Public Law 110–90 and section 1886(d)(3)(vi) of the Act should not be seen as payment cuts, but as offsets to unintended overpayments to hospitals.

Comment: Most commenters, including the AHA, agreed that there were documentation and classification increases that were in excess of the statutory 0.6 percent and 0.9 percent adjustments specified in Public Law 110–90. However, as in prior rulemaking on this issue, most commenters again questioned the methodology employed by MedPAC and our actuaries to determine the magnitude of the excess. These comments were generally similar to or cited the comment from the AHA, which stated in summary:

"The AHA believes there is a fundamental flaw in CMS' methodology for determining the effect of documentation and coding changes on the FY 2008 and FY 2009 CMIs. Specifically, in its analysis, CMS states that the increase in payments it found could not be due to real case-mix change because its analysis looks at only one year of patient claims. However, we assert that the increase cannot be deemed documentation and coding change either, because, again, the analysis looks at only one year of patient claims."

"Our analysis, which used multiple years of patient claims, clearly shows that a significant portion of the change CMS found is actually the continuation of historical trends, rather than the effect of documentation and coding changes due to implementation of MS–DRGs. This analysis found a documentation and coding effect of 0.9 percent for FYs 2008 and 2009."

The AHA also submitted trend analyses in support of its contention that real case-mix is increasing as corroboration of its alternative finding of a documentation and coding effect of 0.9 percent. These materials included a trend analysis of the percentage of Medicare discharges involving the ICU, a trend analysis of data from the Medical Expenditure Panel Survey (MEPS), and a trend analysis of data from the Healthcare Cost and Utilization Project (HCUP).

Some commenters, including the AHA, also stated that even without taking into account the alternative analyses presented by the AHA, the CMS methodology overstates the documentation and classification growth due to an understatement in the CMI value obtained when grouping the FY 2009 claims data through the FY 2007 pre MS–DRG GROUPER. This assertion was also based on a trend analysis.

Response: As stated earlier, we agree with MedPAC's comment that "CMS correctly estimated the effect of DCI on case mix and payments * * *. In our judgment, CMS's analytic methods are valid. Using similar methods, our analysis of Medicare hospital inpatient claims for 2007–2009 confirms all of CMS's findings."

We also agree with the commenters, including the AHA, to the extent that they indicated that there were documentation and classification increases that were in excess of the statutory 0.6 percent and 0.9 percent adjustments specified in Public Law 110–90. However, we disagree with the

commenters' assertion that there is a fundamental flaw in the analytical approach used by our actuaries and MedPAC to determine the magnitude of the documentation and classification increase because our methodology primarily utilizes a single year (FY 2009) of claims data. As stated in prior rulemaking, most recently in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23867), overall case-mix growth is predominately comprised of three factors: Real case-mix growth; a documentation and classification effect; and a measurement effect. Section 7(b)(1)(B) of Public Law 110–90 requires that the Secretary make appropriate adjustment following a determination that the implementation of the MS–DRG system "resulted in changes in coding and classification that did not reflect real changes in case mix." Section 7 of Public Law 110–90 does not require that we use a specific methodology when conducting this analysis, and we believe that the use of the FY 2009 claims data allows us to directly remove real changes in case-mix from the calculation, consistent with the statutory requirement. Differences in case-mix calculated using the pre- and post-MS–DRG GROUPERs on the FY 2009 data, as detailed previously in this final rule, cannot reflect real case-mix change, by definition, because the same set of patients and claims is being processed under the two GROUPERs. The corroborative analyses performed by MedPAC and our actuaries more directly examine shifts in cases from lower severity and cost MS–DRGs to higher severity and cost groups within the same base DRG than the alternative approach submitted by the commenters who asserted that real growth in case mix follows a historical trend line. The alternative approach does not disaggregate the overall growth in case mix into its three components as does the methodology we set forth that MedPAC corroborates. As MedPAC stated in its comment letter:

"The share of cases without a CC or MCC declined more than 6 percentage points in 2008 and an additional 2 percentage points in 2009, while the shares of cases with a MCC increased by more than 6 and 3 percentage points, respectively * * * When we looked at all 259 base DRGs that are split in some fashion based on secondary diagnoses, we found that all but one had essentially the same pattern of shifts in 2008 and 2009 toward the highest severity and cost MS–DRG and away from the lowest severity or cost MS–DRG. In 68 of these base DRGs, the cumulative shift from 2007 to 2009 in the share of cases toward the highest-weighted MS–DRG was at least 10 percentage points."

Nevertheless, despite our position that our methodology more directly measures the relevant increase, we did examine the alternative approach favored by commenters for calculating the documentation and classification increase. As a general statement, the approach of examining historical trends to estimate what case-mix would have been in the absence of the adoption of the MS–DRGs should not necessarily yield significantly different results from the analysis done by our actuaries and MedPAC *if* an appropriate historical trend can be determined. We have concerns about the determination of an appropriate historical trend.

We believe that the determination of an appropriate historical trend is less straightforward than our methodology, which, as described above, simply removes real case-mix growth from the calculation. One issue with the trend analysis is the determination of the appropriate time period on which to base the trend. We note in our examination of the AHA approach that it begins with the case-mix change for FY 2001. MedPAC, in its comment letter, provided an analysis of the change in actual case-mix from FY 1998 to FY 2009:

"We calculated the annual percent change in the national aggregate case-mix index (CMI) for the period from 1997 to 2009. These actual CMI values are based on the DRG version, relative weights, and transfer policies that were in effect for each year. To calculate the percent change for each year, we used national aggregate average CMIs for the cohort of hospitals paid under the IPPS in each pair of adjacent years. We also excluded all hospitals that had converted to critical access hospital status (CAH) by the end of 2009."

We created the following table summarizing the results of MedPAC's analysis.

CHANGES IN CASE MIX FOR IPPS HOSPITALS

Year	Percent
1998	−0.5
1999	−0.7
2000	−0.8
2001	−0.7
2002	0.7
2003	1.0
2994	0.9
2005	0.6
2006	0.4
2007	−0.2
2008	2.0
2009	2.6

We note that the sustained negative changes in actual CMI from FY 1998 through FY 2000 are not reflected in the AHA analysis. If included, they would significantly increase the AHA estimate of documentation and coding growth because the slope of the AHA trend line would be significantly less.

A second critical issue with the AHA approach is the determination of the appropriate cohort of hospitals to include in the calculation. For example, if a hospital converts to CAH status, decisions with respect to the inclusion or exclusion of data from the time period before the conversion will influence the trend analysis. In FY 2000, there were approximately 300 CAHs, but, by FY 2007, there were approximately 1,300 CAHs. We note that MedPAC excluded all hospitals that had converted to CAH status by the end of 2009. It was not apparent how the data from these hospitals was treated in the AHA approach. CAHs tend to have lower than average case-mix values; therefore, including the data from one or more years before the conversion and then excluding the data after the conversion artificially increases the trend line and decreases the magnitude of the documentation and classification estimate.

Given these concerns about the appropriateness of the AHA historical trend, it follows that we are concerned about extrapolating the AHA historical trend into FY 2009. AHA's extrapolation assumes that changes in case-mix increase at a linear and, therefore, consistent rate, when, in fact, changes in case-mix do not necessarily follow a consistent pattern over time, as MedPAC's case-mix analysis pointed out.

After a careful review of the comments, we continue to find the methodology used by our actuaries and MedPAC to determine the magnitude of the changes in coding and classification that did not reflect real changes in case mix to be the most appropriate methodology because it directly removes real changes in case-mix from the calculation consistent with the statutory requirement. We also question the time period and cohort selections made by the AHA in its analysis and the appropriateness of extrapolating this AHA trend to FY 2009 when a much more straightforward methodology exists for estimating documentation and coding growth.

Comment: One commenter, while supporting the proposed FY 2011 adjustment of −2.9 percent, stated that CMS should not implement any further adjustment in FY 2012 without a more detailed quantification of the factors

contributing to case-mix growth so that CMS can separate the factors that should be included in the adjustment from the factors that should be excluded. For example, the commenter appears to believe that the effect of resequencing the diagnosis codes on a claim (as opposed to the addition of new or different diagnosis codes) should not be included in the section 7 adjustments because the commenter believes this is not a documentation and coding change, even if the resequencing results in classification to a higher MS–DRG. Other factors cited by the commenter included new diagnosis codes and certain definitional changes to the base-DRGs.

Response: Section 7 of Public Law 110–90 requires us to adjust for changes in "coding and classification" that do not reflect real changes in case-mix. We believe that the reclassifications cited by the commenter are properly accounted for in the documentation and coding adjustment; these factors may affect the MS–DRG classification and affect payment without a corresponding real increase in patient severity of illness. For this reason, we believe that the effects of these factors are appropriately included in the section 7 adjustments, consistent with section 7(b)(1)(B) of Public Law 110–90, which requires adjustments to the extent that "implementation" of the MS–DRG system results in "coding and classification that did not reflect real change in case-mix."

After consideration of the public comments we received, as well as MedPAC's detailed analysis, we have decided to finalize our proposal to make an adjustment to the standardized amount of −2.9 percent, representing approximately half of the aggregate recoupment adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. We are persuaded by MedPAC's analysis, and by our own review of the methodologies recommended by various commenters, that the methodology we have employed to determine the required recoupment adjustment is sound. We understand the concerns expressed by many commenters about the potential adverse financial effects on hospitals. However, we are required by the statute to implement this adjustment no later than FY 2012. We do not believe that it would be in the interest of hospitals to delay this required adjustment entirely until FY 2012. Rather, we have sought, as we commonly do, to moderate the potential impact on hospitals by phasing in the required adjustment over more than one year. The adjustment to the standardized amount of −2.9 percent that we are finalizing represents approximately half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90 for FY 2011. As we noted in making the proposal, there is a distinct advantage to phasing in the required adjustment in this manner. As we stated above, a major advantage of making the −2.9 percent adjustment to the standardized amount in FY 2011 is that, because the required recoupment adjustment is not cumulative, we can anticipate removing the 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 then 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 again note this anticipated effect of the FY 2011 policy, we have not yet made a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012. Nevertheless, this anticipated consequence of adopting a −2.9 percent adjustment for FY 2011 should substantially reduce the potential financial impact of this required adjustment on hospitals. We believe that this is a reasonable and fair approach which satisfies the requirements of the statute while substantially moderating the impact on hospitals.

FY 2011 MS–DRG Documentation and Coding Adjustment

	Required prospective adjustment for FYs 2008–2009	Required recoupment adjustment for FYs 2008–2009	Total adjustment	Recoupment adjustment to FY 2011 payments	Remaining adjustment
Level of adjustments	−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 patient 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. 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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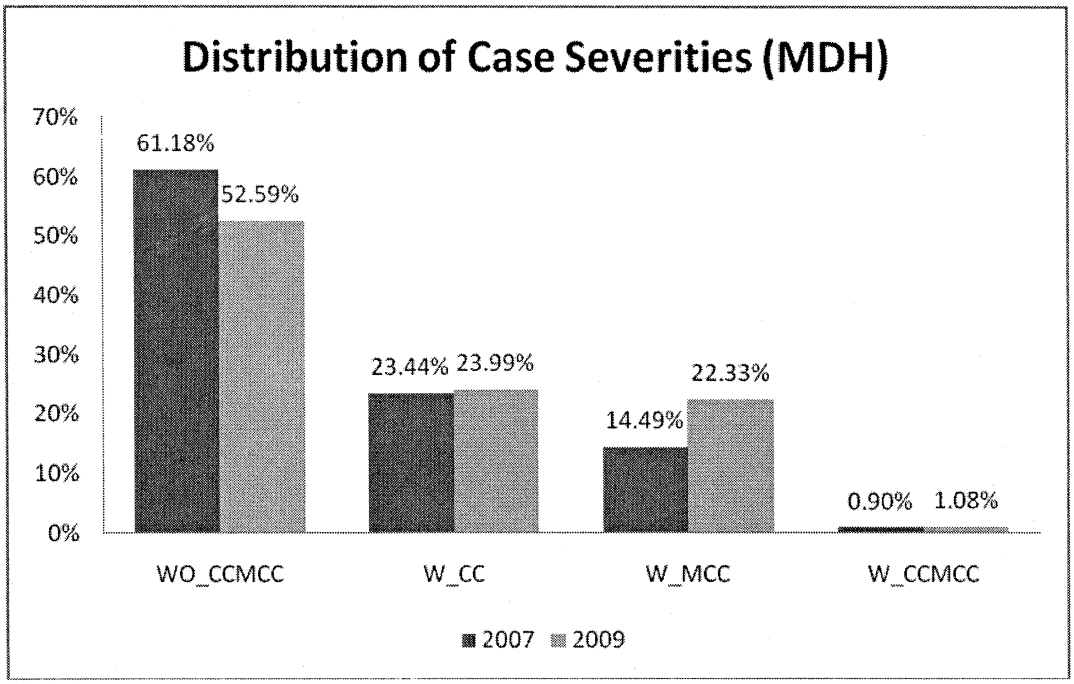

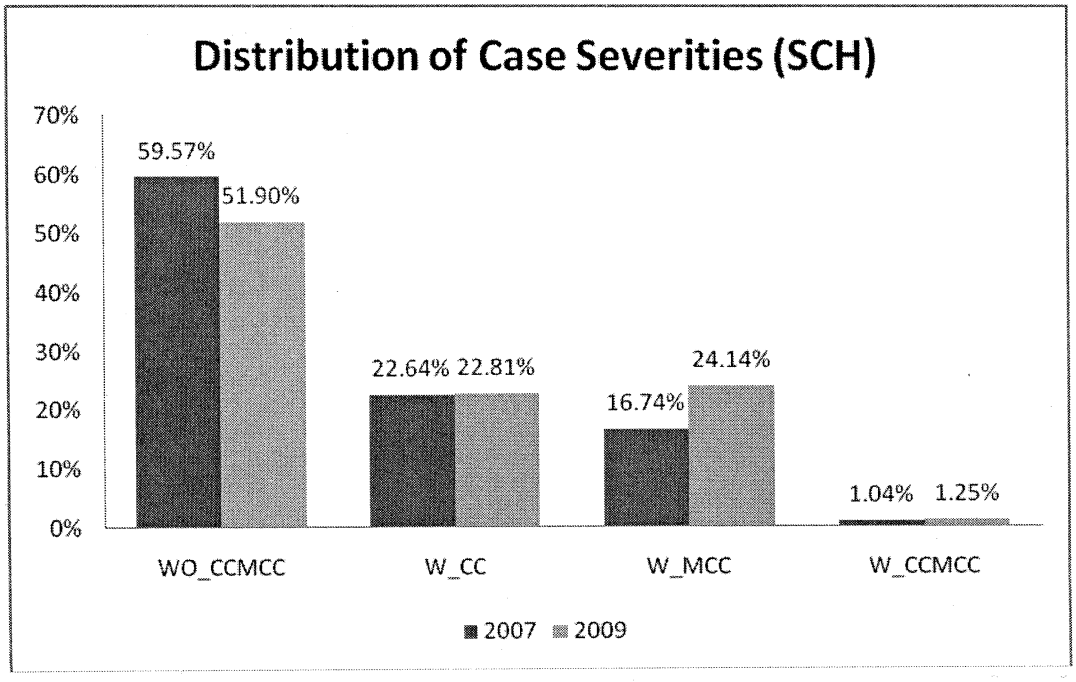

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Consistent with our analysis of IPPS hospitals, the two charts above show that we found after analysis of FY 2009 discharge data that the distribution of severity discharges for MDHs and SCHs both proportionally shifted from the without CC/MCC to with MCC category. This analysis was updated to include data for FY 2009 claims paid through March 2010. Similarly, we found using a methodology consistent with our analysis of IPPS hospitals that 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 patient 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, in the FY 2011 IPPS/LTCH PPS proposed rule, we proposed 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 patient 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 proposed 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 did not propose to implement the entire adjustment that is warranted by our data (in this case, 5.4 percent) in one year. Second, we proposed to maintain 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 represented somewhat over half of the entire adjustment that is appropriate for SCHs and MDHs, it would allow 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 proposed 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 indicated in the proposed rule that 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we sought 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 rulemaking 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 stated that we intended to update our analysis with FY 2009 data on claims paid through March 2009 (sic) for this FY 2011 IPPS/LTCH PPS final rule and have updated our analysis with FY 2009 data on claims paid through March 2010 in this FY 2011 IPPS/LTCH PPS final rule. (We note that the March 2009 update date for claims paid data in the proposed rule should have been March 2010.)

Comment: Numerous commenters requested that CMS withdraw its proposal to apply the documentation and coding adjustment to SCHs and MDHs and questioned CMS' statutory authority to apply this adjustment to providers receiving a hospital-specific rate. The commenters argued that because section 1886(d)(3)(A)(vi) of the Act only authorizes application of a documentation and coding adjustment to the standardized amount, Congress' specific instruction as to the applicability of this type of adjustment makes it impermissible for CMS to apply the adjustment to the hospital-specific rates. Furthermore, commenters contend that, due to their critical role in isolated communities, any negative documentation and coding adjustment to SCHs and MDHs would endanger their ability to provide the type of care that Congress specifically sought to protect by establishing their special Medicare payment systems.

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

Comment: MedPAC responded to our request for comments regarding the level of adjustment for special categories of hospitals, such as hospitals paid under the hospital-specific payment rate, by pointing out that these hospitals have the same financial incentives for documentation and coding improvements and the same ability to benefit from increased payments that do not reflect real changes in case-mix severity of illness levels. Therefore, MedPAC recommended that "all IPPS hospitals should be treated the same." At the same time, MedPAC also stated that "delaying prevention of overpayments * * * creates a problem because overpayments will continue to accumulate in 2010 and later years until the effect of documentation and coding improvement is fully offset in the payment rates." In setting forward its multiyear recommendation to CMS for complying with the requirements of section 7 of Public Law 110–90, MedPAC emphasized "minimizing the accumulation of overpayments."

Response: We thank MedPAC for its comments and agree that it is appropriate to conclude that hospitals paid under the hospital-specific rate have experienced a 5.4 percent increase in documentation and coding in FYs 2008 and 2009, insofar as these hospitals had the same financial incentives to improve documentation and coding as other IPPS hospitals, as

confirmed by the analysis we have described above. We further agree with MedPAC that it is appropriate to focus on minimizing the accumulation of overpayments; we interpret this statement to mean that MedPAC recommends that CMS move forward as quickly as possible with appropriate prospective adjustments. We appreciate MedPAC's guidance that "all hospitals be treated the same," and we agree that it is important to treat various classes of similarly situated hospitals in our payment policy determinations in a consistent manner.

Therefore, we are finalizing our proposal to apply an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. This adjustment is prospective in nature. We continue to believe that such an adjustment is appropriate because, as MedPAC noted, all hospitals have the same financial incentives for documentation and coding improvements, and the same ability to benefit from the resulting increase in aggregate payments that do not reflect real change in case-mix severity of illness levels. As we describe above, our analysis of claims data shows that the documentation and coding effect for all IPPS hospitals is similar to the effect for SCHs and slightly different to the effect for MDHs, and we believe the documentation and coding estimates for all subsection (d) hospitals should be the same. This adjustment also maintains, as much as possible, consistency in the treatment of various classes of hospitals that are similarly situated with respect to their ability to adjust their documentation and coding practices. Specifically, this adjustment is consistent with our adjustment for other IPPS hospitals in two ways. First, as in the case of the IPPS adjustment, we are not implementing the entire adjustment that is warranted by our data (in this case, 5.4 percent) in 1 year. Second, we are treating hospitals in a consistent manner by applying the same numerical level of adjustment for both groups of hospitals in FY 2011. While this adjustment to the hospital-specific rates represents somewhat over half of the entire adjustment that is appropriate for SCHs and MDHs, it would allow 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 proposed for other IPPS hospitals, we believe that applying equal numerical adjustments in this first year is the most appropriate means to maintain such consistency and equity at this time. As we indicated in the proposed rule, 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.

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

a. Background

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 patient 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.

b. 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.

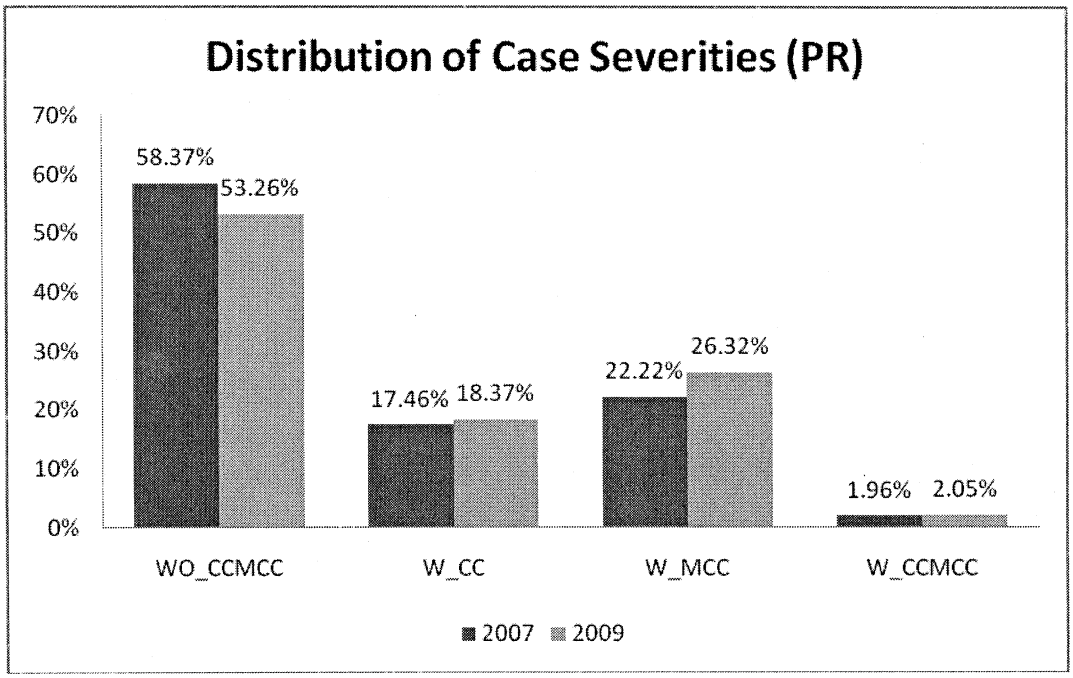
In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24101), we solicited public comment on the proposed −1.1 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our intent to address in the FY 2011

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 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 patient 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 corresponding increase in the discharge severity with MCCs compared to a decrease in discharge severity in the without CC/MCC category. This analysis reflects FY 2009 claims paid through March 2010.

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 (FY 2009 claims paid through March 2010), is that a cumulative adjustment of −2.6 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 −2.6 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 MS–DRG system was smaller for Puerto Rico hospitals as compared to IPPS hospitals and SCHs and MDHs. Therefore, in the FY 2011 IPPS LTCH PPS proposed rule (75 FR 23876), we proposed 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 proposed 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 noted that the proposed prospective adjustment would have eliminated the full effect of the documentation and coding changes (as estimated at the time) on the portion of future payments to Puerto Rico hospitals based on the Puerto Rico-specific rate. We believe that this a full prospective 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. (As discussed below, the estimated −2.4 percent adjustment that we calculated in the proposed rule no longer represents a "full prospective adjustment.") One reason for proposing the full prospective adjustment for the Puerto Rico-specific rate in FY 2011 was to maintain equity as much as possible in the documentation and coding adjustments applied to various hospital rates in FY 2011. Because our proposal was to make an adjustment that represents the full adjustment that is warranted for the Puerto Rico-specific rate, we indicated that we do not anticipate proposing any additional adjustments to the this rate for documentation and coding effects.

In the FY 2011 proposed rule, we sought public comment on the proposed full prospective adjustment, which we estimated at that time to be −2.4 percent, to the Puerto Rico-specific standardized amount under section 1886(d)(5)(I)(i) of the Act. We stated that we intended to update our analysis with FY 2009 data on claim paid through March 2009 (sic) for this FY 2011 IPPS/LTCH PPS final rule. (We note that the March 2009 update date for claims paid data in the proposed rule should have been March 2010.) We have updated our analysis, as planned, with FY 2009 data on claims paid through March 2010 in this FY 2011 IPPS/LTCH PPS final rule. This updated data analysis shows that a cumulative adjustment of −2.6 percent is required to eliminate the full effect of the document and coding changes on future payments from the Puerto Rico-specific rate.

Comment: MedPAC responded to our request for comments regarding the level of adjustment for special categories of hospitals, such as Puerto Rico hospitals, by pointing out that these hospitals have the same financial incentives for documentation and coding improvements and the same ability to benefit from increased payments that do not reflect real change in case-mix severity of illness levels. Therefore, MedPAC recommended that "all IPPS hospitals should be treated the same." At the same time, MedPAC also stated that "delaying prevention of overpayments * * * creates a problem because overpayments will continue to accumulate in 2010 and later years until the effect of documentation and coding improvement is fully offset in the payment rates." In setting forward its multiyear recommendation to CMS for complying with the requirements of section 7 of Public Law 110–90, MedPAC emphasizes "minimizing the accumulation of overpayments."

Response: We thank MedPAC for its comments and agree that Puerto Rico hospitals have had the same financial incentives to improve documentation and coding as other IPPS hospitals. We further agree with MedPAC that it is appropriate to focus on minimizing the accumulation of overpayments; we interpret this statement to mean that MedPAC recommends that CMS move forward as quickly as possible with appropriate prospective adjustments. We appreciate MedPAC's guidance that "all hospitals be treated the same," and we agree that it is important for our payment policy determinations to treat various classes of hospitals that are similarly situated with respect to the ability to adjust their documentation and coding practices in as consistent a manner as possible.

Therefore, we are finalizing our proposal to apply an adjustment to the Puerto Rico specific rate in FY 2011 using our authority under section 1886(d)(5)(I)(i) of the Act as proposed (that is, a full prospective adjustment). We note that our updated data analysis shows that this adjustment will be −2.6 percent. We continue to believe that such an adjustment is appropriate because, as MedPAC found, all hospitals have the same financial incentives for documentation and coding improvements and the same ability to benefit from the resulting change in case-mix. As we indicated in the proposed rule, 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.

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 public 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. Proposed and Final Policy Changes 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 55.30 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. The public comments on the July 2, 2009 **Federal Register** notice were incorporated in a **Federal Register** notice that was issued on April 30, 2010 (75 FR 22810). We now plan to issue the final hospital cost report Form CMS–2552–10 later this summer. However, in part, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23878 through 23880), we provided a summary of the public comments received on the July 2, 2009 notice that specifically related to the relative weights and responded to those comments. Our responses to the comments in the FY 2011 IPPS/LTCH PPS proposed rule constituted 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 cost 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 B 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.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23879), we stated that, at that time, we did not know the impact on CCRs and estimated costs of adopting standard cost centers specific to CT scanning and MRI. However, we stated our belief that these areas constitute significant payment under both the IPPS and OPPS and that these are common imaging services already widely reported by hospitals. Therefore, in the proposed rule, we proposed to adopt new standard cost centers for CT scanning and MRI. We agreed 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.

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. In the proposed rule, we indicated that 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, minor equipment, and supplies for diagnostic nuclear medicine services can be reported. Major moveable equipment should be allocated to this cost center on Worksheet B unless the provider received approval from its contractor for direct assignment of the costs (Provider Reimbursement Manual (PRM), Part I, Section 2307). 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.

Comment: Commenters both supported and opposed our proposal to establish standard cost centers for the reporting of costs for CT scanning and for MRI. Some commenters supported the proposal because they agree with RTI's finding that there is aggregation bias in the radiology cost centers. RTI found that CT and MRI scans have a significantly higher markup in their respective nonstandard cost centers or subscripted standard cost center lines than most other radiology services. The commenters indicated that when CMS uses the overall radiology department CCR that "ignores" costs and charges reported in the CT and MRI nonstandard cost centers and other subscripted cost centers to convert charges to costs for CT and MRI scans, 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. These commenters believed that the creation of standard cost centers for CT scanning and MRI services will result in more accurate estimation of the cost of these services.

Some commenters who objected to the proposal believed that it is premature to establish these new standard cost centers without understanding the payment implications of these changes on both IPPS relative weights and OPPS payments. The commenters were concerned that adoption of these cost centers would result in very low CCRs for these services, as already observed in the nonstandard cost centers and estimated by RTI in its July 2008 report. Some commenters stated that if the proposal were finalized, they believe that a chest CT scan would be paid at the same level as a routine chest X-ray under the OPPS. Commenters also were concerned that estimating costs on claims data using CCRs based on cost and charge data from standard cost centers for CT scanning and MRI services would adversely impact payment for the technical component of imaging services paid under the Medicare Physician Fee Schedule (MPFS), which is capped at the level paid under the OPPS fee schedule. Commenters suggested that CMS examine all the costs incorporated into CT scans and MRI services before accepting very low CCRs for these services. Some commenters suggested that CMS should analyze the CCR methodology by performing specific procedure cost comparisons of low value versus high value diagnostic imaging equipment for both inpatient and outpatient settings to ensure that the CCRs accurately reflect the cost of capital equipment used in the procedure cost.

Response: After consideration of these comments, we continue to believe that the creation of standard cost centers for CT scanning and MRI services is necessary because of the potentially significant improvement in the accuracy of estimated costs, as recommended by RTI. We understand the commenters' concerns that the final CCRs for CT scans and MRI maybe low in light of current cost report data findings and that this may result in lower payment for CT scans and MRI services. We do not believe that we can assess whether inappropriate payments would result with our current data and, for that reason, we believe that we should collect standard cost center cost and charge data for these areas, using those data to assess the resulting CCRs specific to CT scanning and MRI services as a means of eliminating aggregation bias for these and other radiology services in the IPPS and OPPS. Therefore, we are establishing standard cost centers for CT scanning and MRI services in hospital cost reports for cost report periods beginning on or after May 1, 2010. We believe that establishing these standard cost centers is necessary to improving the accuracy of estimating costs for imaging services and will allow us to perform the impact assessment that some commenters want us to do.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23880), we also noted that 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, and therefore, the data from the proposed standard cost centers for CT scans, MRI, and cardiac catheterization respectively, should they be finalized, would not even be available for possible use in calculating the relative weights earlier than 3 years after Form CMS–2552–10 becomes available. We stated that 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. Therefore, we wish to reassure the commenters that there is no need for immediate concern regarding possible negative payment impacts on MRI and CT scans under the IPPS and OPPS because the cost report data that would be used for the calculation of the relative weights is at least 3 years from being available. We will first thoroughly analyze and run impacts on the data and provide the public with the opportunity to comment, as usual, before distinct CCRs for MRI and CT scans would be finalized for use in the calculation of the relative weights. Our decision to finalize our proposal regarding cost centers for these services is only the first step to a longer process during which we will continue to consider public comment.

In this final rule, we are finalizing our proposal to create standard cost centers for MRI and CT scans on the new Medicare cost report Form CMS–2552–10, and urge all hospitals to properly report their costs and charges for MRI, CT scans, and all other services so that, in several years' time, we will have reliable data from all hospitals on which to base a decision as to whether to incorporate additional CCRs into the relative weight calculation. We note that the impact on physician payment for the technical component of these services that results from changes to payment to hospitals is not within scope of the proposed rule.

Comment: Some commenters stated that the current reporting of the high cost of CT and MRI equipment results in inaccurate estimates of the cost of these services. Specifically, they asserted that some hospitals consider CT and MRI equipment costs to be capital costs, which are spread across various cost centers based on square footage or another allocation methodology, resulting in an underallocation of capital costs to the radiology department and CT and MRI nonstandard cost centers and inappropriately low CCRs for these services. In addition, the commenters believed that some hospitals report CT and MRI equipment costs as part of hospital fixtures and not as moveable equipment, allocating their direct capital costs across the whole hospital, rather than to the radiology cost center. One commenter stated the revised Medicare cost report Form 2552–10 recommended using a simplified cost allocation methodology where movable equipment is allocated on a square footage basis, which appeared contrary to the IPPS proposed rule that discussed that a dollar value could be used as the statistical basis for cost allocation.

Finally, some commenters stated that hospitals do not have an incentive to report these costs accurately in disaggregated cost centers, given the time and resources to do the cost allocation. They believed that hospitals have a modest incentive to spread their capital cost across all services rather than allocating imaging equipment costs in the imaging cost centers. One commenter argued that because many

non-Medicare third party payers continue to pay hospitals on the basis of a percentage of charges and, to the extent that specific allocation of equipment and other capital costs to MRI and CT scans reduces the charges for other services, hospital may have a financial *disincentive* to specifically allocate those costs. The commenter also pointed out that, in some States, cost reporting practices are required to conform to State regulatory requirements, which may be inconsistent with specific allocation of capital costs.

Response: Section 104 of the PRM–1 contains definitions of buildings (section 104.2), building equipment (section 104.3), major moveable equipment (section 104.4), and minor equipment (section 104.5) that apply for purposes of cost report completion. We believe that it is clear that CT and MRI equipment are "major moveable equipment" and are neither a building cost nor a building equipment cost. Specifically, section 104.4 of the PRM–1 defines "major moveable equipment" as follows: "The general characteristics of this equipment are: (a) A relatively fixed location in the building; (b) capable of being moved, as distinguished from building equipment; (c) a unit cost sufficient to justify ledger control; (d) sufficient size and identity to make control feasible by means of identification tags; and (e) a minimum life of approximately three years. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, x-ray machines, etc." In addition to this longstanding instruction, we believe that our view that CT scanning and MRI equipment are major moveable equipment is supported by the 2008 edition of "Estimated Useful Lives of Depreciable Hospital Assets," which states that the estimated useful life of a CT scanner is 5 years, an MRI is 5 years, and an X-ray unit is 7 years. Therefore, we believe that our longstanding policy makes it clear that CT scanning and MRI equipment is major moveable equipment and should be reported as such on the cost report. As major moveable equipment, the costs should be reported together with the rest of the hospital's major moveable equipment cost in the "Capital Related Cost—Moveable Equipment" cost center(s) on Worksheet A (lines 2 and 4). The costs in this cost center are allocated to all the hospital's cost centers that use major moveable equipment (including CT and MRI) using "dollar value" or "square feet" if the provider obtained the contractor's approval under Provider Reimbursement Manual, Part II (PRM–II), Section 3617, to use the simplified cost allocation methodology. However, a hospital that is concerned that this method of allocation may result in inaccurate CCRs (on Worksheet C, Part I) for the CT scan, MRI, and other ancillary cost centers may request contractor approval under section 2307 of the PRM–I to directly assign the cost of moveable equipment to all of the hospital's cost centers that use moveable equipment, including CT scans and MRI. If the hospital meets all of the criteria in section 2307 of the PRM–I, the contractor may approve the direct assignment method. This would ensure that the high cost of the CT scanning and MRI equipment would be reflected in the CCR that would be calculated for those departments and that would be used to estimate the cost of CT scanning and MRI services. In any case, hospitals with accounting systems that include the cost of CT scanning and MRI equipment in the "Capital Related Costs—Building and Fixtures" cost center should correct their cost reporting practices to come into compliance with CMS longstanding policy in this regard. Reporting of costs and charges on the Medicare cost report must be compliant with Medicare cost reporting principles, regardless of differing payment structures and incentives of other payers or State reporting requirements.

Comment: Commenters raised concerns about rural hospitals being unable to accurately report costs in CT scanning, MRI and cardiac catheterization cost centers. One commenter noted that rural hospitals, like CAHs, provide some of these radiology services internally or through arrangement, and that it is difficult for them to track the costs for these cost centers. The commenter requested that CAHs be exempt from the requirement to report their costs in the proposed standard cost centers. Other commenters noted that the proposed creation of a standard cardiac catheterization cost center would pose a significant burden to hospitals to change their cost reporting to allocate costs to this cost center. In particular, they stated that smaller hospitals may have fewer resources to be able to separate their costs and charges for these cost centers, which would pose a significant burden. The commenters indicated that, for example, while revenue code 481 "Cardiology-Catheterization Lab" contains cardiac catheterization charges, there are some revenue codes that contain other charges for cardiac catheterization, like revenue codes 360 and 361, "Operating Room-General" and "Operating Room-Minor," respectively.

Response: As we stated in the CY 2009 OPPS final rule (73 FR 68522), with regard to creation of new cost centers, hospitals that do not currently maintain distinct departments or accounts in their internal accounting systems for CT scanning, MRI, or cardiac catheterization are not required to create distinct departments or accounts. We do not expect additional burden for reporting under these new standard cost centers to be significant because hospitals that provide these services and maintain a separate account for these services in their internal accounting records to capture the costs and charges are currently required in accordance with § 413.53(a)(1) to report these cost centers in the cost report, even if CMS does not identify a cost center code for the department(s). Specifically, under those regulations defining the departmental method of cost apportionment, the hospital must separately apportion the cost of each ancillary department. CMS defines a cost center in PRM–I, Section 2302.8, as an organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated, and apportioned. With respect to the comments regarding the revenue codes for cardiac catheterization, if the hospital operates a separate department for cardiac catheterization and maintains a separate General Ledger account for this department, the hospital would be expected to report the costs and charges in the new cardiac catheterization standard cost center and ensure that the charges are billed under appropriate UB revenue codes.

Comment: Some commenters supported the proposal to create a standard cost center for cardiac catheterization services. However, some commenters objected to the proposal to create a standard cost center for Cardiac Catheterization. Some commenters were uncertain whether it would have a significant impact on charge compression and believed that it may not be necessary to secure more accurate estimated costs. Commenters were concerned that RTI's analysis of charge compression in the cardiology cost centers may be flawed; when RTI analyzed the costs and charges included in the current nonstandard cardiac catheterization cost center, RTI hypothesized that the nonstandard cardiac catheterization cost center contains costs from services that were not cardiac catheterization. As such,

commenters believed that hospitals may not be reporting their costs appropriately for this cost center.

Response: We continue to believe that it is appropriate to create a standard cost center to capture the cost and charges of cardiac catheterization services in hospitals that maintain the cost of such services in distinct departments or accounts, and that standardizing where hospitals report their costs and charges for cardiac catheterization will improve the estimation of the cost of this high volume Medicare service for both the IPPS and the OPPS. Moreover, once the information from a standard cardiac catheterization cost center is available, we will carefully evaluate the effect on the CCRs that are derived from these data and will make the decision regarding whether to implement the resulting CCRs, as usual, through our public **Federal Register** proposed and final notice process. However, in this final rule, we are finalizing our proposal to add a standard cost center to the cost report for cardiac catheterization.

Comment: Commenters opposed a regression-based approach for addressing charge compression in the relative weights where CMS would use regression-based CCRs in the relative weights methodology. The commenters preferred more accurate and uniform cost reporting, to mitigate charge compression in the cost-based relative weights.

Response: We agree that more accurate cost reporting is a better means of mitigating charge compression than applying regression-based adjustments and, for this reason, have proposed to create certain cost centers that we believe will ultimately result in more refined CCRs, thereby leading to better estimates of hospital cost for MRI, CT scanning, and cardiac catheterization services about which the public has repeatedly raised concerns due to the hospital practice of setting charges for low cost services at a much higher percentage of cost than the percentage by which the charge for high cost services exceeds the cost of those services.

Comment: One commenter stated that CMS should work closely with the hospital industry for comprehensive cost report reform rather than have piecemeal changes to the cost report. The commenter believed that CMS' collaboration with the industry would promote cost report simplification.

Response: We have just completed a major redesign of the hospital cost report in which the public had multiple opportunities to provide input to the specific proposed revisions. However, that larger redesign, reassessment, and revision effort does not negate the need to make additional targeted changes as appropriate to resolve particular identified problems, such as aggregation bias in the payment for devices, CT scanning, MRI services and cardiac catheterization. As discussed above, the proposal to create standard cost centers for CT scanning, MRI services and cardiac catheterization evolved from the findings of the RTI report of aggregation bias in the payment of several types of services paid under the IPPS and OPPS, including, but not limited to, high cost medical devices for which CMS created a standard cost center for cost report periods beginning on and after May 1, 2009. We believe that the creation of standard cost centers for CT scanning, MRI services, and cardiac catheterization is both appropriate and that CMS has provided numerous opportunities for public input.

Comment: One commenter recommended that CMS issue explicit, unambiguous guidance to hospitals on how to improve allocation of large capital costs to the radiology cost center. The commenter noted that the draft Medicare cost report Form 2552–10 did not provide any mandatory reporting guidance to hospitals on how to improve the accuracy of cost allocation for imaging equipment.

Response: We believe that the current instructions on allocation of the cost of major moveable equipment needed to provide CT scans, MRIs, and other radiology services are clear. We refer readers to the regulations at 42 CFR 413.24(b) and 413.24(f) and CMS instructions in Sections 2304 through 2320 of the PRM–I and Sections 3617 and 3618 of the PRM–II.

Comment: One commenter raised a number of concerns about what CT and MRI information hospitals should report in these cost centers. Those concerns include whether equipment installation or de-installation or equipment maintenance costs are reported in this cost center and whether costs associated with supplies related to MRI and CT equipment (like diagnostic contrast agents) are reported in this cost center. The commenter speculated whether each new item of advanced diagnostic equipment warranted a new cost center. The commenter requested that CMS provide guidance to the hospital industry on what types of costs should be reported in these cost centers.

Response: As with any other ancillary cost center, the providers would report the direct cost accumulated in the CT scanning or MRI departmental accounts that are reflected in the general ledger working trial balance.

Comment: One commenter recommended that CMS work with the Medicare contractors to simplify the cost allocation process, which the commenter found to be lengthy and burdensome. The commenter stated that if hospitals want to change the order of allocation or their allocation statistics, they must make a written request to their fiscal intermediary or MAC 90 days prior to the end of the cost reporting period. The commenter stated that the hospital must demonstrate that the change more accurately allocates costs and provide supporting documentation. The fiscal intermediary or MAC has 60 days to decide whether or not to approve or deny the request, while the provider must maintain both sets of cost allocation statistics in the meantime. The commenter requested that CMS simplify this process.

Response: We believe that the current process provides Medicare contractors with the minimum time needed to evaluate a contractor request to change the order of allocation or their allocation statistics, given the importance of the decision and the need for the contractor to assess whether the change would result in a more valid determination of hospital costs.

Comment: Commenters encouraged CMS to ensure that hospitals are appropriately allocating costs to the Implantable Devices Charged to Patients cost center, which was a standard cost center that we added for cost report periods beginning on and after May 1, 2009, as a result of the findings of the RTI report that there is aggregation bias in our estimates of the cost of expensive medical devices.

Response: Hospitals are expected to comply with our regulations at 42 CFR 413.24(b)(1) and 413.24(f) and to follow the instructions in Sections 2304 through 2320 of the PRM–I and Sections 3617 and 3618 of the PRM–II, as well as all other related instructions when allocating cost to the Implantable Devices Charged to Patients cost center. Medicare contractors review how hospitals allocate costs on the Medicare cost report for all cost centers, including the Implantable Devices Charged to Patients cost center, in accordance with their audit plans.

Comment: One commenter opposed the HSRV methodology for standardization of the relative weights. The commenter found this methodology to be inappropriate in a cost-based relative weight methodology and only appropriate for removing the effects of different markup practices in a charge-based relative weight methodology.

Response: We appreciate the comment but note that we did not

propose any changes with respect to the HSRV methodology for standardizing the relative weights.

In summary, we are establishing standard cost centers for CT scanning, MRI services, and cardiac catheterization in hospital cost reports for cost report periods beginning on or after May 1, 2010.

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 259 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 an 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

Beginning in FY 2007, we have proposed, solicited, and responded to public comments and have implemented section 1886(d)(4)(D) of the Act through the IPPS annual rulemaking process. For specific policies addressed in each rulemaking cycle, we direct readers to the following publications: the FY 2007 IPPS proposed rule (71 FR 24100) and final rule (71 FR 48051 through 48053); the FY 2008 IPPS proposed rule (72 FR 24716 through 24726) and final rule with comment period (72 FR 47200 through 47218); the FY 2009 IPPS proposed rule (73 FR 23547), and final rule (73 FR 48471); and the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106) and final rule (74 FR 43782). A complete list of the 10 current categories of HACs is included in section II.F.2. of this preamble.

In the FY 2011 IPPS/LTCH proposed rule (75 FR 23880 through 23898), we did not propose any additional HACs or changes to policies already established under the authority of section 1886(d)(4)(D) of the Act.

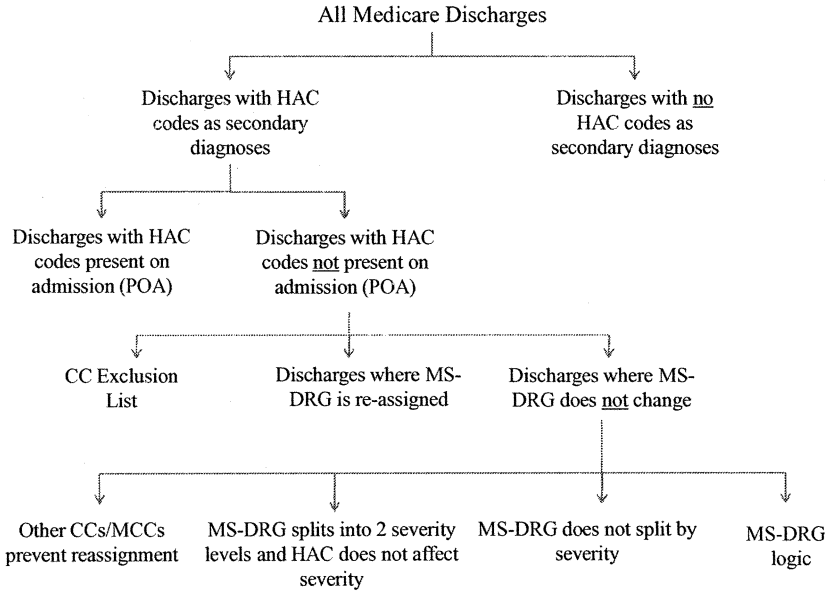
c. Collaborative Process

As noted in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23881), 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 obtain 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 with comment period (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 2011 IPPS/LTCH PPS proposed rule (75 FR 23880 through 23898), we did not propose to add or remove categories of HACs, nor did we propose any changes to previously established policies.

Given the timeliness of the HAC discussion, particularly when considered within the context of recent legislative health care reform initiatives, however, we remain eager to engage in an ongoing public dialogue about the various aspects of this policy. We plan to continue to include updates and findings from the RTI evaluation on CMS' Hospital-Acquired Conditions and Present on Admission Indicator Web site available at: *http://www.cms.hhs.gov/HospitalAcqCond/.*

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. In the FY 2011 IPPS/LTCH PPS proposed rule, we listed the instructions and change requests that were issued to IPPS hospitals and also to non-IPPS hospitals regarding the submission of POA indicator data for all diagnosis codes on Medicare claims and the processing of non-PPS claims (75 FR 23381) We also indicated that specific instructions on how to select the correct POA indicator for each diagnosis code were 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.* We reiterate that 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* although, 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 continue to collaborate with the AHA to promote the *Coding Clinic for ICD–9–CM* as the source for coding advice about the POA indicator.

As discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23882) as well as in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43784), 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 final payment policies 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.

On or after January 1, 2011, hospitals are required to begin reporting POA indicators using the 5010 electronic transmittal standards 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 currently being used because of reporting restrictions from the use of the 4010 electronic transmittal standards format.

Comment: Several commenters supported CMS' plans to no longer require a POA indicator of "1" for codes exempt from the POA reporting requirement with the implementation of the new 5010 electronic transaction standards.

Response: We appreciate the commenters' support of our efforts to move to the new 5010 electronic transaction standards format. We agree that the use of this format will prove beneficial for a number of reasons, including POA indicator reporting as well as facilitating the move to the use of ICD–10 coding systems.

Hospitals 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 plan to issue CMS instructions on this reporting change.

2. 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 modify the list of selected HACs to reflect these changes. In Table 6A in the Addendum to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24207), we 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 proposed to delete code 999.6 and form a new subcategory of code 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24210), we proposed 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 esignation
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 invited 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.

Comment: Several commenters supported CMS' proposal to add new ICD–9–CM codes 999.60, 999.61, 999.62, 999.63, and 999.69, to replace code 999.6, to specify ABO incompatibility reaction for FY 2011 and their classification as CCs.

Response: We appreciate the support of the commenters. We are finalizing our proposal to make code 999.6 an invalid code and to add codes 999.60, 999.61, 999.62, 999.63, and 999.69 as CCs to the HAC blood incompatibility category for FY 2011.

Comment: Some commenters questioned why the five ICD–9–CM codes (999.60, 999.61, 999.62, 999.63, and 999.69) were being proposed to replace the existing code (999.6) to identify blood incompatibility when the analysis indicated that only an extremely low volume of discharges (23) reported this condition as a secondary diagnosis.

Response: The five ICD–9–CM codes listed above were proposed and finalized through the ICD–9–CM Coordination and Maintenance Committee meeting process. Further information regarding the diagnosis coding proposal for Hemolytic Transfusion Reactions (HTR) from the September 17, 2009 meeting can be located at the following CDC Web site: *http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm.*

For the reasons set forth in the proposed rule, we are finalizing our proposal to make code 999.6 an invalid code and to add codes 999.60, 999.61, 999.62, 999.63, and 999.69 as CCs to the HAC blood incompatibility category for FY 2011.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23882 and 23883), we also invited public comment on our proposal that the current list of HAC categories and the ICD–9–CM codes that had been finalized through FY 2010 continue to be subject to the HAC payment provision for FY 2011. We also indicated that the final FY 2011 list of HAC conditions would include the proposed five new refinement codes to identify blood incompatibility as CCs if these codes were finalized. We received public comments on our proposal that the listed conditions continue to be subject to the HAC payment provisions which are summarized below.

Comment: One commenter stated that the current HAC categories and codes finalized through FY 2010 are, for the most part, rational based on the statutory criteria that HACs must be high cost, high volume, or both and reasonably preventable through the application of evidence based guidelines. However, the commenter expressed reservations regarding the inclusion of deep vein thrombosis (DVT) and pulmonary embolism (PE) following certain orthopedic procedures. The commenter stated that the proportion of these events that can be prevented with evidence-based guidelines is unclear, given that there is uncertainty about the ideal length of time DVT prophylaxis should be continued postoperatively, differing practices and guidelines for DVT prophylaxis, and patient-specific factors (that is, thrombophilia) that can impact risk of postoperative venous thromboembolism. The commenter stated that an unintended consequence

of this HAC category could be excess bleeding occurrences from longer prescriptions of anticoagulation in attempts to comply with the measure. The commenter stated that, rather than including DVTs and PEs under the HAC provision, these conditions may be more appropriately managed as a measure under the RHQDAPU, as is being proposed for reducing avoidable readmissions.

Response: We appreciate the commenter's support for the current HAC categories. We also appreciate the commenter's concern regarding whether DVTs and PEs following certain orthopedic procedures are reasonably preventable, given evidence-based guidelines. We are providing data on the frequency of our 10 categories of HACs for the first time in this year's rulemaking. As the public reviews these data and evaluates the effectiveness of the HAC program, we will be soliciting recommendations for refinements to this list. As discussed earlier, section 1886(d)(4)(D) of the Act specifies that the HAC list of conditions may be revised, in consultation with CDC, from time to time as long as the list contains at least two conditions. We did not propose any modification to the HAC list in the proposed rule. We instead shared data on the HACs, which we have discussed earlier. As we move forward, we will be working with the health care industry to refine and update the HAC list. Therefore, we will not remove DVTs and PEs following certain orthopedic procedures from the HAC list at this time.

Comment: One commenter requested that CMS clarify how a hospital can appeal a decision under which a particular patient falls under the HAC policy and is ineligible for a higher DRG payment. The commenter believed that an appeals process is essential to ensure accountability.

Response: As we explained in the FY 2008 IPPS final rule (72 FR 47216), under 42 CFR 412.60(d), a hospital has 60 days after the date of the notice of the initial assignment of a discharge to an MS–DRG to request a review of that assignment. The hospital may submit additional information as part of its request. A hospital that believes a discharge was assigned to the incorrect MS–DRG as a result of the payment adjustment for HACs may request review of the MS–DRG assignment by its fiscal intermediary or MAC consistent with § 412.60(d) of the regulations.

As final policy for FY 2011, the following conditions will continue to be subject to the HAC payment provision:

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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	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
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

HAC	CC/MCC (ICD-9-CM Code)
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

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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 the HACs selected through FY 2010.

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 were completed prior to the publication date of the FY 2011 IPPS/LTCH PPS proposed rule. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23883 through 23898), we summarized the analyses that were completed. 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.

We received a number of public comments regarding the evaluation conducted by RTI, despite the fact that we did not propose any new policies or policy revisions based on the evaluation. Several of these public comments are addressed later in another section of this preamble, but we believe that it is appropriate to acknowledge the following issues here.

Comment: Several commenters expressed concern that the RTI evaluation did not include an analysis on the costs of complying with the HAC–POA provision. According to the commenters, compliance with our HAC–POA policy results in additional costs to providers and individuals, as well as to the Medicare program by necessitating additional expensive preadmission screening tests in order to achieve more accurate admission documentation. The commenters also stated that the estimated savings to Medicare is not accurate if providers are utilizing additional resources to perform these expensive tests on their patients.

Response: We understand the seriousness of this concern and refer to our original discussion of HAC–POA issues in the FY 2009 IPPS final rule (73 FR 23547 through 23559) in which we included a comprehensive discussion of what we understood to be the full impact of this policy. We will continue to evaluate the financial costs of compliance with our HAC–POA program, as well as its impact on our overall goal of providing the highest quality of care for Medicare beneficiaries at the most reasonable costs.

Comment: Several commenters commended CMS for making the early findings of the RTI study, as well as HAC–POA data, available to the public. The commenters encouraged CMS to continue to make additional findings available.

Response: We agree with the commenters that it continues to be important to make HAC–POA data and findings available to the public prior to proposing any significant updates to the HAC list. As RTI continues its work, we will share the findings and additional HAC–POA data.

Comment: Several commenters expressed interest in seeing data on the most common secondary diagnoses on the CC and MCC list that are reported along with an HAC code.

Response: We have asked RTI to include a list of the most commonly reported secondary CC and MCC diagnoses and display this list along with the other HAC–POA data on its Web site at: *http://www.rti.org/reports/cms*.

In this final rule, we are updating our summary of the analyses with additional data that have become available since issuance of the proposed rule.

b. 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.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23880 through 23898), we provided a preliminary analysis on claims data from October 2008 through June 2009. Since publication of that proposed rule, an additional 3 months of data for FY 2009 that include claims from July 2009 through September 2009 have become available. Below we present the cumulative results of RTI's findings for FY 2009.

Using MedPAR claims data from October 2008 through September 2009, RTI found a total of approximately 65.22 million secondary diagnoses across approximately 9.3 million discharges. As shown in Chart A below, the majority of all secondary diagnoses (83.69 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		9,298,503	
Total Number of Secondary Diagnoses Across Total Discharges		65,224,895	100.00
POA	**Indicator Description**		
Y	Condition present on admission	54,588,241	83.69
W	Status cannot be clinically determined	15,639	0.02
N	Condition not present on admission	4,379,972	6.72
U	Documentation not adequate to determine if condition was present on admission	138,825	0.21
1	Exempted ICD-9-CM code	6,102,218	9.36

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

c. 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 9.3 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 153,284 HAC-associated diagnosis codes being reported for that HAC category. Of these 153,284 diagnoses, 5,684 reported a POA indicator of "N" for not POA and 147,257 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 17 HAC-associated secondary diagnosis codes (and procedure codes) reported. It is important to note that the number of secondary diagnosis codes classified as POA is likely overstated due to coding practices, and, therefore, the number of HACs not POA are expected to be greater than indicated in Charts B and C. As a result, these data likely underestimate the number of complications some would consider acquired in the hospital or other health care setting. For example, the HACs listed as present on admission (POA = "Y") include those instances where the HAC condition was present on admission from the emergency room or other outpatient settings within the admitting institution. The POA indicator of "Y" is also used to identify cases where a patient was discharged and then readmitted one calendar day or more after the date of discharge due to complications from a HAC. In addition, the POA indicator of "Y" may also include patient transfers to the acute care hospital from other health care facilities, like nursing homes, or from a home health setting, where the secondary diagnosis considered to be a HAC was initially acquired. Using current coding guidelines, all of the above scenarios can be correctly and appropriately classified as POA (where POA = "Y") on an inpatient claim, and CMS does not have data from which to determine where the condition described in the secondary diagnisos was acquired. Therefore, while a fraction of the HACs reported as POA were acquired outside the hospital prior to admission, some conditions could also have been acquired at the hospital in an outpatient setting or through a prior admission.

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

Selected HAC	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA = N		POA = U		POA = Y		POA = W	
		No.	Percent	No.	Percent	No.	Percent	No.	Percent
1. Foreign Object Retained After Surgery (CC)	441	189	42.9	0	0.0	252	57.1	0	0.0
2. Air Embolism (MCC)	33	24	72.7	0	0.0	9	20.3	0	0.0
3. Blood Incompatibility (CC)	28	8	28.6	0	0.0	20	71.4	0	0.0
4. Pressure Ulcer Stages III & IV (MCC)	105,092	1,311	1.2	56	0.1	79,165	98.7	25	0.0
5. Falls and Trauma (MCC & CC)	153,284	5,684	3.7	270	0.2	147,257	96.1	73	0.0
6. Catheter-Associated UTI (CC)	14,089	2,323	16.5	19	0.3	11,717	83.2	30	0.2
7. Vascular Catheter-Associated Infection (CC)	6,933	2,555	36.9	22	0.3	4,342	62.6	14	0.2
8. Poor Glycemic Control (MCC)	14,303	435	3.0	10	0.1	13,851	96.8	7	0.0
9A. Surgical Site Infection Mediastinitis CABG (CC)	35	26	74.3	0	0.0	8	25.7	0	0.0
9B. Surgical Site Infection Following Certain Orthopedic Procedures (CC)	260	157	60,4	1	0.4	101	38.8	1	0.4
9C. Surgical Site Infection Following Bariatric Surgery for Obesity (CC)	17	15	88.2	0	0.0	2	11.8	0	0.0
10. Pulmonary Embolism & DVT Orthopedic (MCC)	3,377	2,505	74.2	17	0.5	832	24.6	23	0.7
Total*	297,892	15,232	5.1	404	0.1	257,556	86.5	178	0.1

* Discharges can appear in more than one row. The total figure is not adjusted for the 60 discharges with more than one HAC that appear as secondary diagnoses (15 of these discharges resulted in MS-DRG reassignment).

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In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23885), we welcomed public comments on the data presented that could provide insight into the accuracy of those data, the use of comparative data sets or analysis, and how aspects of the coding system might influence these data.

Comment: One commenter expressed its past and continuing support of the HAC–POA program. This commenter applauded CMS' efforts to evaluate the payment and clinical impacts of the HAC–POA policy and for making the preliminary data available for public comment. However, the commenter reported that it found the preliminary published POA data for certain conditions interesting. Specifically, the commenter noted that the POA data for the catheter-associated urinary tract infection (CAUTI) condition was unexpected in that 85 percent of the cases reporting that condition as a secondary diagnosis were assigned a POA indicator of "Y" (meaning that the condition was present on admission). The commenter further noted that there were other conditions whose POA data analysis results were equally unexpected. This commenter stated it looked forward to reviewing further

analyses and understanding how the POA indicator is being documented and the accuracy of the documentation.

Response: We appreciate and acknowledge the commenter's support of the HAC–POA provision. As stated earlier, one aspect of the HAC–POA program evaluation is to examine the accuracy of coding, which includes a review of the POA indicator data. RTI will continue to study these data and, when they become available, we plan to publish the results.

Comment: Commenters expressed concern about the accuracy of POA indicator reporting for the HACs related to intracranial injury with loss of consciousness. One commenter stated that it has come to the attention of the American Hospital Association's Central Office on ICD–9–CM that there have been different interpretations of the POA coding guidelines for the reporting of the following ICD–9–CM code categories:

- 850 Concussions;
- 851 Cerebral laceration and contusion;
- 852 Subarachnoid, subdural, and extradural hemorrhage, following injury;
- 853 Other and unspecified intracranial hemorrhage following injury; and
- 854 Intracranial injury of other and unspecified nature.

The commenter pointed out that the above mentioned ICD–9–CM code categories require a fifth digit to specify whether there was a loss of consciousness, and the approximate length of time that the patient was unconscious. The commenter stated that, currently, the POA guidelines state to "assign 'N' if any part of the combination code was not present on admission." The commenter further indicated that, in some instances, coders have assigned "N" to these codes if the patient lost consciousness after admission, even though the intracranial injury occurred prior to admission. The commenter stated that loss of consciousness is a component of intracranial injuries rather than a separate condition. The commenter believed that this guideline has resulted in data implying that the intracranial injuries were a result of trauma sustained after admission to the hospital, when the injury occurred prior to admission.

The commenter stated that this POA guideline was discussed by the Editorial Advisory Board for *Coding Clinic for ICD–9–CM.* After review, the commenter stated that the Board determined that the POA guideline should be clarified so that coders will understand that these intracranial injury cases that have a loss of consciousness after admission should be assigned a POA indicator of "Y" rather than a "N." The commenter stated that this advice will be provided in a future issue of *Coding Clinic for ICD–9–CM.* The commenter pointed out that CMS collaborated in this decision.

Response: We agree that there appears to be inconsistency in how coders interpret and apply the official POA coding guideline for these combination codes that include loss of consciousness. CMS participated as a voting member of the American Hospital Association's Editorial Advisory Board for *Coding Clinic for ICD–9–CM* to develop clarifications on the POA reporting for combination codes that involve loss of consciousness. We agree that this clarification will lead to greater consistency and accuracy in POA indicator reporting. CMS looks forward to continuing its efforts as part of the American Hospital Association's Editorial Advisory Board for *Coding Clinic for ICD–9–CM* to provide guidance on accuracy of coding and the reporting of POA indicators. Hospitals look to this publication to provide detailed guidance on ICD–9–CM code and POA reporting. We encourage hospitals to send any other questions about ICD–9–CM codes or POA indicator selection to the American Hospital Association so that the Editorial Advisory Board can continue its role of providing instruction on the accurate selection and reporting of both ICD–9–CM codes and POA indicators.

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 data on a total of 404 HAC-associated secondary diagnoses reported with a POA indicator of "U." Of those diagnoses, 270 (0.2 percent) were assigned to the Falls and Trauma HAC category.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23885), we stated that we continue to believe that better documentation will result in more accurate public health data. Because the RTI analysis we summarized in the FY 2011 IPPS/LTCH PPS proposed rule was based on preliminary data, we did not propose 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."

Comment: Several commenters asked CMS to change our policy under which we do not pay at the higher CC/MCC amount when a HAC code reported with a POA of "U." (A POA indicator of "U" means that documentation was insufficient to determine if the condition was present at the time of the inpatient admission.) The commenters stated that while hospitals are continuing to work on coding and documentation improvement issues with physicians who practice in their facilities, in some cases, hospitals have not been successful in obtaining clear documentation to clarify whether or not a condition was present on admission. They added that when physicians do not provide clear documentation in the medical record, a POA indicator of "U" is assigned. The commenters asked that CMS allow these cases with poor documentation to result in a higher payment if the HAC code is reported with a "U."

Response: We are committed to improving the accuracy of health care data. Accurate and complete documentation within the health record is important for patient management, outcome measurement, and quality improvement, as well as payment accuracy. We believe that it would be inappropriate to pay a higher amount to hospitals based on incomplete or poor documentation. If accurate information is not available within the health record for a hospital to report a precise POA indicator, hospitals are encouraged to seek this additional documentation from their physicians and/or other hospitals if the hospital treated a patient who was transferred. For these reasons, we believe that reducing payment for conditions on the HAC list with poor documentation is appropriate. Therefore, we did not propose to change our approach to discounting the CC or MCC assignment for selected HACs reported with a POA indicator of "U." We will maintain our existing policy and not allow HACs with a POA indicator of "U" to lead to the higher payment.

In the FY 2011 IPPS/LTCH PPS proposed rule, we encouraged 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 updated detailed RTI report, readers can view that code 998.4 was reported 428 times and code 998.7 was reported 13 times, for a total of 441 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. 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 33 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 33 reported discharges, 24 discharges (72.73 percent) had a POA indicator of "N" or "U" and was identified as a HAC discharge. There were a total of 24 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 (50 percent of the 24 discharges with a POA indicator of "N" or "U"). Thus, while there were 24 discharges (72.73 percent of the original 33) 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 (50 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 264,810 discharges with a HAC-associated diagnosis as a secondary diagnosis, 3,416 discharges ultimately resulted in MS–DRG reassignment. As we discuss 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) Pulmonary Embolism and DVT Orthopedic (Orthopedic PE/DVT); (3) Pressure Ulcer Stages III & IV; 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 126,078 discharges. Of these 126,078 discharges, 5,312 (4.21 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 5,312 discharges within this HAC category that were not POA, 1,577 (29.69 percent) resulted in an MS–DRG reassignment.

Of the 264,810 total discharges reporting HAC-associated diagnoses as a secondary diagnosis, 3,110 discharges were coded with a secondary diagnosis of Orthopedic PE/DVT. Of these 3,110 discharges, 2,335 (75.08 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 2,335 discharges in this HAC category that were not POA, 1,024 discharges (43.85 percent) resulted in an MS–DRG reassignment.

The Pressure Ulcer Stages III & IV category had the second most frequently coded secondary diagnoses, with 99,656 discharges. Of these discharges, 1,316 (1.32 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 1,316 discharges in this HAC category that were not POA, 384 discharges (29.18 percent) resulted in an MS–DRG reassignment.

The Catheter-Associated UTI category had the third most frequently coded secondary diagnoses, with 14,089 discharges. Of these discharges, 2,333 (16.56 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 2,333 discharges in this HAC category that were not POA, 223 discharges (9.56 percent) resulted in a MS–DRG reassignment.

The remaining 6 HAC categories only had 208 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 26 of the 2,573 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 417 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 (44 cases), Falls and Trauma (311 cases), Catheter-Associated UTI (9 cases), Vascular Catheter-Associated Infection (4 cases), and Manifestations of Poor Glycemic Control (49 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 264,810 discharges with a reported HAC-associated secondary diagnosis. Of the total 264,810 discharges, 14,681 (5.68 percent) discharges included HACs that were reported with a POA indicator of "N" or "U" and were identified as a HAC discharge. Of these 14,681 discharges, the number of discharges resulting in MS–DRG reassignments was 3,416 (22.72 percent).

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CHART C.—DISCHARGE FREQUENCIES OF CURRENT CMS HACS OCTOBER 2008 THRUGH SEPTEMBER 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	441	0.00	189	42.86	42	22.22
2. Air Embolism	33	0.00	24	72.73	12	50.00
3. Blood Incompatibility	28	0.00	8	28.57	0	0.00
4. Pressure Ulcer Stages III & IV	99,656	1.07	1,316	1.32	384	29.18
a. Stage III	55,722	0.60	951	1.71	322	33.86
b. Stage IV	49,370	0.53	381	0.77	68	17.85
5. Falls and Trauma	126,078	1.36	5,312	4.21	1,577	29.69
a. Fracture	113,306	1.22	4,639	4.09	1,355	29.21
b. Dislocation	895	0.01	27	3.02	4	14.81
c. Intracranial Injury	12,066	0.13	602	4.99	226	37.54
d. Crushing Injury	36	0.00	2	5.56	0	0.00
e. Burn	1,896	0.02	76	4.01	6	7.89
f. Electric Shock	575	0.01	11	1.91	1	9.09
6. Catheter-Associated UTI	14,089	0.15	2,333	16.56	223	9.56
7. Vascular Catheter-Associated Infection	6,933	0.07	2,573	37.11	26	1.01
8. Poor Glycemic Control	14,135	0.15	395	2.79	116	29.37
9a. SSI Mediastinitis	35	0.04	26	74.29	6	23.08

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)
CABG						
9b. SSI Orthopedic	255	0.25	155	60.78	5	3.23
9c. SSI Bariatric	17	0.12	15	88.24	1	6.67
10. Pulmonary Embolism & DVT Orthopedic	3,110	0.80	2,335	75.08	1,024	43.85
Total[1]	264,810		14,681		3,416	

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 60 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 9,298,503. For HAC 9a, this is 94,346. For HAC 9b, this is 101,309. For HAC 9c, this is 14,068. For HAC 10, this is 386,501.
[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 September 2009.

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An extremely small number of discharges had multiple HACs reported during the same stay. In reviewing the 9.3 million claims, RTI found 60 cases in which two HACs were reported on the same discharge. Chart D below summarizes these cases. There were 9 cases in which a Falls and Trauma HAC was reported in addition to a Pressure Ulcer Stages III & IV HAC. Twenty of the cases with two HACs involved Pressure Ulcer Stages III & IV and 24 cases involved Falls or Trauma. Other multiple HAC cases included 10 Catheter-Associated UTI cases and 6 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 60 claims, 15 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.g.(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 SEPTEMBER 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
1. Foreign Object – CC				1
2. Air Embolism – MCC		1		
5. Falls and Trauma – MCC & CC	9			
6. Catheter-Associated UTI – CC	3	6		
7. Vascular Catheter-Associated Infection – CC	5	5	7	
8. Poor Glycemic Control - MCC	1			1
9B. Surgical Site Infection Following Certain Orthopedic Procedures– CC			2	1
10. Pulmonary Embolism & DVT Orthopedic – MCC	2	12	1	3
Total	20	24	10	6

e. 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 96 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 8,208 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 was the only secondary diagnosis reported, 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 a total of 1,793 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 1,255 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 nine 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 nine cases that did not result in MS–DRG reassignment due to the MS–DRG logic were in the Catheter Associated UTI HAC category, three cases were in the Falls and Trauma HAC category, one case was in the Foreign Body Retained After surgery HAC category, and one case was in the Vascular Catheter-Associated Infection HAC Category.

In conclusion, a total of 11,265 cases (8,208 + 1,793 + 1,255 + 9) did not have a change in MS–DRG assignment, regardless of the presence of a HAC. The reasons described above explain why only 3,416 cases had a change in MS–DRG assignment despite the fact that there were 14,681 HAC cases with a POA of "N" or "U." We refer readers to the RTI detailed report at the Web site: *http://www.rti.org/reports/cms* for further information.

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CHART E.—REASONS HAC DID NOT CHANGE MS-DRG ASSIGNMENT OCTOBER 2008 THROUGH SEPTEMBER 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	441	189	42	96	44	6	1
2. Air Embolism – MCC	33	24	12	10	0	2	0
3. Blood Incompatibility-CC	28	8	0	4	3	1	0
4. Pressure Ulcer Stages III & IV – MCC	99,656	1,316	384	736	0	196	0
5. Falls and Trauma – MCC & CC	126,078	5,312	1,577	2,721	477	534	3
6. Catheter-Associated UTI- CC	14,089	2,333	223	1,661	303	142	4
7. Vascular Catheter-Associated Infection – CC	6,933	2,573	26	2,109	137	300	1
8. Poor Glycemic Control – MCC & CC	14,135	395	116	236	1	42	0
9A. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) – MCC	35	26	6	16	0	4	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	255	155	5	88	57	5	0
9C. Surgical Site Infection Following Bariatric Surgery for Obesity – CC	17	15	1	14	0	0	0
10. Pulmonary Embolism & DVT Orthopedic – MCC & CC	3,110	2,335	1,024	517	771	23	0
Total[1]	264,810	14,681	3,416	8,208	1,793	1,255	9

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 60 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 September 2009

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

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23892), we discussed RTI's preliminary analysis on coding changes using 9 months of claims data from October 2008 through June 2009. We noted that, 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. For this FY 2011 IPPS/LTCH PPS final rule analysis, RTI examined an additional 3 months of claims data for each fiscal year (FY 2007 and FY 2008), and compared these data to the updated FY 2009 data. Below we summarize the results of the fiscal year to fiscal year comparison using 12 months of claims data.

RTI's analysis found that there was an overall 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 Catheter-Associated UTI HAC category, with 12,459 discharges being reported in FY 2007, while 15,408 discharges were reported in FY 2008, an increase of 2,949 cases. The next significant increase was in the Falls and Trauma HAC category with 151,321 discharges being reported in FY 2007, while 153,600 discharges were reported in FY 2008, an increase of 2,279 cases.

However, the analysis also found that there was an overwhelming decrease in the HAC-associated secondary diagnoses reported from FY 2008 to FY 2009. The most significant decrease was in the Falls and Trauma HAC category, with 153,600 discharges being reported in FY 2008, while 125,505 discharges were reported in FY 2009, a decrease of 28,095 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. RTI Analysis of Estimated Net Savings for Current HACs

RTI estimated the net savings generated by the HAC payment policy based on 12 months of MedPAR claims from October 2008 through September 2009.

(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. A 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: Rerun 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 FY 2007 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.

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 FY 2007 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.

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 September 2009, based on the methodology described above. Column A shows the number of discharges where a 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 SEPTEMBER 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	42	$153,046	$3,644
2. Air Embolism	12	$148,394	$12,366
3. Blood Incompatibility	0	$0	$0
4. Pressure Ulcer Stages III & IV	384	$2,156,113	$5,615
5. Falls and Trauma	1,577	$8,093,391	$5,132
a. Fracture	1,355	$6,979,013	$5,151
b. Dislocation	4	$16,506	$4,127
c. Intracranial Injury	226	$1,150,807	$5,092
d. Crushing Injury	0	$0	$0
e. Burn	6	$21,639	$3,607
f. Shock	1	$12,749	$12,749
6. Catheter-Associated UTI	223	$642,003	$2,879
7. Vascular Catheter-Associated Infection	26	$85,254	$3,279
8. Poor Glycemic Control	116	$611,428	$5,271
9a. SSI Mediastinitis CABG	6	$57,676	$9,613
9b. SSI Orthopedic	5	$43,958	$8,792
9c. SSI Bariatric	1	$2,381	$2,381
10. Pulmonary Embolism & DVT Orthopedic	1,024	$6,919,410	$6,757
Total[1]	3,416	$18,779,932[2]	$5,522

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 60 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 September 2009.

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As shown in Chart F above, the total net savings calculated for the 12-month period from October 2008 through September 2009 was roughly $18.78 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 $17.17 million of net savings for the 12 month period. Estimated net savings for the 12-month period associated with the Falls and Trauma category were $8.09 million. Estimated net savings associated with Orthopedic PE/DVT for the 12-month period were $6.92 million. Estimated net savings for the 12-month period associated with Pressure Ulcer Stages III & IV were $2.16 million.

The mean net savings per discharge calculated for the 12-month period from October 2008 through September 2009 was roughly $5,522. 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 12-month period of FY 2009 analyzed by RTI had multiple HACs during the same stay. In reviewing our 9.3 million claims, RTI found 60 cases where two HACs were reported on the same admission as noted in section II.F.3. d. of this preamble. Of these 60 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 SEPTEMBER 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 part of an array of Medicare VBP tools that we are using to promote increased quality and efficiency of care. We again 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 should 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—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 9.3 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 85,096 secondary diagnoses codes being reported for that condition, of which 28,844 reported a POA indicator of "N"; (2) Staphylococcus aureus Septicemia, with a total of 22,433 secondary diagnoses codes being reported for that condition, with 5,004 of those reporting a POA indicator of "N"; and (3) Iatrogenic Pneumothorax, with a total of 20,673 secondary diagnoses codes being reported for that condition, with 17,602 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 SEPTEMBER 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)	85,096	28,844	33.9	452	0.5	55,657	65.4	143	0.2
2. Delirium	659	163	24.7	1	0.2	495	75.1	0	0.0
3. Legionnaire's Disease	386	25	6.5	4	1.0	357	92.5	0	0.0
4. Staphylococcus aureus Septicemia	22,433	5,004	44.3	60	0.6	17,330	154.8	39	0.3
5. Methicillin-Resistant Staphylococcus aureus	70,620	2,325	6.0	163	0.8	68,089	192.7	43	0.4
6. Iatrogenic Pneumothorax	20,673	17,602	85.1	15	0.1	3,056	14.8	0	0.0
7. Ventilator-Associated Pneumonia	4,214	3,245	77.0	5	0.1	962	22.8	2	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 85,096 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 85,096 discharges, 29,296 discharges (34.43 percent) had a POA indicator of "N" or "U." Therefore, there were a total of 29,296 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 896 (3.06 percent). Thus, while there were 29,296 discharges with CDAD reported with a POA indicator of "N" or "U" that could potentially have had an MS–DRG reassignment, the result was 896 (3.06 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 203,844 discharges with a previously considered candidate HAC reported as a secondary diagnosis. Of those, 57,902 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 3,527.

CHART I.--PREVIOUSLY CONSIDERED "CANDIDATE" HAC DISCHARGE FREQUENCIES--OCTOBER 2008 THROUGH SEPTEMBER 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)	85,096	0.92	29,296	34.43	896	3.06
2. Delirium	659	0.01	164	24.89	15	9.15
3. Legionnaire's Disease	386	0.00	29	7.51	2	6.90
4. Staphylococcus aureus Septicemia	22,397	0.24	5,060	22.59	109	2.15
5. Methicillin-Resistant Staphylococcus aureus (MRSA)	70,419	0.76	2,486	3.53	2	0.08
6. Iatrogenic Pneumothorax	20,673	0.22	17,617	85.22	2,501	14.20
7. Ventilator-Associated Pneumonia	4,214	0.05	3,250	77.12	2	0.06
Total[1]	203,844		57,902		3,527	

[1] Discharges can appear in more than one row.
[2] Percent computed relative to total cases "at risk," which is 9,298,503 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 September 2009.

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

The RTI program evaluation includes an updated 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.

Comment: Several commenters stated that CMS should not pay for HACs only when evidence-based guidelines indicate that the occurrence of an event can be reduced to zero, or near zero. The commenters stated that some patients, particularly high-risk, co-morbid individuals, may still develop conditions on the HAC list even though protocols have been strictly followed.

Response: We thank the commenters for this comment. The statute requires that CMS only choose conditions to be selected HACs if they could "reasonably" be prevented through the application of evidence-based guidelines. We noted in the FY 2008 IPPS final rule that we only selected those conditions where, if hospital personnel are engaging in good medical practice, the additional costs of the hospital-acquired condition will, in most cases, be avoided (72 FR 47201).

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. Final Policy Regarding Current HACs and Previously Considered Candidate HACs

We believe that the updated 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, in the

FY 2011 IPPS/LTCH PPS proposed rule, we did not propose to add or remove categories of HACs, although we proposed to revise the Blood Incompatibility HAC category as discussed and finalized in section II.F.2. of this preamble. We also note that in section II.F.3.b. of this preamble, we discuss 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. Changes to Specific MS–DRG Classifications

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23898 through 23910), we invited 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 proposed changes to the MS–DRG classifications based on our analysis of claims data. In other cases, we proposed to maintain the existing MS–DRG classification based on our analysis of claims data. Below, we also summarize the public comments that we received, if any, on our proposals, present our responses to these comments, and state our final policies.

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). 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). These MS–DRGs are assigned to MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders).

As we stated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23898), 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, in that proposed rule, we proposed 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 proposed to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 010 (Pancreas Transplant).

Comment: Commenters concurred with CMS' proposal to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 008. In addition, the commenters concurred with the proposal to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 010.

Response: We appreciate the support for our proposals.

We are adopting as final without modification our proposals to add diagnosis code 251.3 to the list of acceptable principal diagnoses in MS–DRG 008 and, as a conforming change, to add diagnosis code 251.3 to the list of acceptable principal or secondary diagnoses in MS–DRG 010.

b. Bone Marrow Transplants

As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23898), 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 been destroyed by high doses of chemotherapy and/or radiation treatment. Currently, all bone marrow transplants are assigned to MS–DRG 009 (Bone Marrow Transplant).

For the FY 2011 IPPS/LTCH PPS proposed rule, 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, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23898 and 23899), we proposed 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). We proposed that 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

We proposed that 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)

Comment: Several commenters supported our proposed changes and stated that these proposed MS–DRGs more precisely recognize the substantial differences in clinical complexity and costs associated with allogeneic and autologous bone marrow transplants, allowing for more appropriate hospital reimbursement.

Response: We appreciate the support of the commenters.

Comment: Two commenters who supported the proposed reclassification of the proposed bone marrow transplant MS–DRGs requested further refinement to account for severity of illness. The commenters suggested a three-way split for each proposed MS–DRG: With MCC, with CC, and without MCC or CC. A few commenters stated that the clinical and cost differences between unrelated and related allogeneic transplants necessitate further reclassification of proposed MS–DRG 014. However, one of the commenters pointed out that there were no ICD–9–CM codes to classify allogeneic transplant cases by cell source.

Response: As we outlined in our FY 2008 IPPS/LTCH PPS final rule with comment period published in the **Federal Register** on August 22, 2007 (72 FR 47169), in designating an MS–DRG as one that would be subdivided into subgroups based on the presence of a CC or an MCC, we developed a set of criteria to facilitate our decision-making process. In order to warrant creation of a CC or an MCC subgroup within a base MS–DRG, the subgroup must meet all of the following five criteria:

- A reduction in variance of charges of at least 3 percent.
- At least 5 percent of the patients in the MS–DRG fall within the CC or MCC subgroup.
- At least 500 cases are in the CC or MCC subgroup.
- There is at least a 20-percent difference in average charges between subgroups.
- There is a $4,000 difference in average charges between subgroups.

We did not further subdivide proposed MS–DRG 014 and MS–DRG 015 into severity levels as the commenters suggested because the proposed MS–DRGs did not meet our criteria for subdivision. With regard to the commenter who stated that there were no ICD–9–CM codes to classify allogeneic transplant cases by cell source, we note that, contrary to the commenter's statement about the lack of being able to report the donor source, there are three ICD–9–CM procedure codes that identify the donor source of the transplant: 00.91 (Transplant from live related donor); 00.92 (Transplant from live non-related donor); and 00.93 (Transplant from cadaver). We refer the commenter to section II.G.7. of this preamble for further information if the commenter is interested in submitting suggestions on coding issues.

After consideration of the public comments we received, we are finalizing our proposal to delete MS–DRG 009, and to create two new MS–DRGs: MS–DRG 014 (Allogeneic Bone Marrow Transplant) and MS–DRG 015 (Autologous Bone Marrow Transplant). New MS–DRG 014 will include cases reported with one of the following ICD–9–CM procedure codes: 41.02; 41.03; 41.05; 41.06; or 41.08.

New MS–DRG 015 will include cases reported with one of the following ICD–9–CM procedure codes: 41.00; 41.01; 41.04; 41.07; or 41.09.

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, 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 in the hierarchy than the next six MS–DRGs relating to brain injury. 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. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23899), we indicated that we were then able to address the commenter's concern because we had been able to conduct an analysis of MedPAR claims data for this diagnosis code for that proposed rule.

For the FY 2011 proposed rule, we undertook an analysis of MedPAR claims data for FY 2009. Our analysis reflected the data study specifically asked for by the requestor, that is, a review of the analysis of the presence or absence of diagnosis code V45.88. For our analysis in the proposed rule, we did not include claims for patient cases assigned to MS–DRGs 061, 062, or 063. Patients whose cases were assigned to these MS–DRGs would have been given the tPA at the initial hospital, had they been admitted there, 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 if it had already been administered at the transferring hospital; therefore, inclusion of procedure code 99.10 on the receiving hospital's 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). We believe that claims assigned to MS–DRGs 067, 068, and 069 were 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. This analysis can be viewed in the FY 2011 IPPS/LTCH PPS proposed rule published in the **Federal Register** on May 4, 2010 (75 FR 23899 through 23900). Based on our review of the data for all cases in MS–DRGs 064, 064, 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 was not warranted.

We determined that the differences in the average lengths of stay and the average costs were too small to warrant an assignment to the higher weighted MS–DRGs. Likewise, neither the lengths of stay nor the average costs were deemed 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 did not propose any change to MS–DRGs 061, 062, 063, 064, 065, or 066, or any change involving the assignment of diagnosis code V45.88.

Comment: One commenter agreed with CMS' proposal to not make any changes to this group of MS–DRGs. The commenter also suggested revisiting this topic and reviewing the data after CMS begins capturing 25 diagnosis codes and 25 procedure codes in future claims data. Another commenter suggested that diagnosis code V45.88 may be underreported, or, even if reported, may appear in a position [on the claim] that is lower than the nine diagnosis codes currently processed by Medicare.

Response: The HIPAA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update is discussed at length elsewhere in this preamble. Currently, CMS' claims processing system recognizes up to nine diagnosis codes and up to six procedure codes for MS–DRG determination. The ability to process up to 16 additional diagnosis codes and up to 19 additional procedure codes will begin on January 1, 2011, according to the Version 5010 update. We will be interested to see the difference in our MedPAR data that results from the additional diagnosis and procedure codes, and we will continue to follow the tPA, "drip-and-ship," and diagnosis code V45.88 topic in our annual analysis.

Comment: One commenter requested that CMS continue to monitor the costs and lengths of stays for these patients identified by diagnosis code V45.88 in order to determine whether, with improved coding compliance and accurate cost reporting, there will be any change to the initial findings such that MS–DRG assignments for the care of these patients need to be changed.

Response: We review MS–DRG assignments annually and will continue to monitor this category of patients in the future.

Comment: One commenter believed that the CMS data reported in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23899 through 23900) reflects that the V45.88 diagnosis code is being underused and that the numbers do not truly represent the much more common occurrence of stroke centers receiving stroke patients who already had tPA administered. With this underuse in mind, the commenter requested that CMS issue a transmittal or *MLN Matters* article that would inform physicians and coders alike about the existence of the code and simultaneously educate them on the proper use of the code.

Response: While CMS is responsible for both changes to the ICD–9–CM procedure coding system through the ICD–9–CM Coordination and Maintenance Committee and the incorporation of the resulting diagnostic and procedure coding changes in CMS' initiatives, we do not provide coding advice. CMS looks to our partners in the industry to fulfill this responsibility, specifically through the AHA in their publication *Coding Clinic for ICD–9–CM* and through the AHIMA in their coding training programs.

In addition, we suggest that this commenter encourage its societies to educate their members through their newsletter or through coding and documentation presentations at society meetings.

Comment: One commenter was concerned that the data analysis described above and displayed in the proposed rule did not properly compare certain patient populations. The commenter suggested that patients with ICD–9–CM codes associated with

ischemic stroke that have an accompanying V-code be compared to those ischemic stroke patients with the ICD–9–CM codes who were not treated with tPA. The commenter suggested limiting the MS–DRGs to 064, 065, and 066, as well as 067 and 068, and further noted that the V-code should only be used for ischemic stroke patients who have received tPA at another hospital. The commenter believed that ischemic stroke patients who have not received tPA at another hospital should not be included in the V-code count. The commenter also recommended that cases in which hemorrhage is the cause of the stroke should not be included with cases of ischemic stroke since costs associated with these diseases are often different from each other. The commenter indicated that a more refined analysis of the data would show that these cases should be split into separate MS–DRGs, which would allow the cost differences to become apparent.

Response: With regard to use of the V-code for ischemic stroke patients who have received tPA at another hospital, we point out that the correct use of V45.88 was created for that category of patients. Correct coding practice as well as the code title itself of V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) precludes inclusion of this code by the sending hospital.

With regard to the comment that ischemic stroke patients who have not received tPA at another hospital should not be included in the V-code count, we point out that these patients had not been included in the analysis published in the proposed rule; neither were they included in the analysis presented in this final rule. They would not appear in the data as having received tPA at another facility. Instead, if they had received tPA at the second or receiving hospital, that hospital would have coded those cases with ICD–9–CM procedure code 99.10 (Injection or infusion of thrombolytic agent), and the cases would have been assigned to MS–DRGs 061, 062, and 063 (Acute Ischemic Stroke with use of Thrombolytic Agent with MCC, with CC, or without CC/MCC, respectively).

In our original analysis for the proposed rule, we believe that we did address all of the commenter's concerns. However, for this final rule, in response to the commenter's request, we have arrayed the data from the original analysis in the following table in a manner that is divided into more categories. We also have included MS–DRGs 067 and 068 in the comparison as well, per the commenter's request.

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MS-DRG	Number of cases	Average length of stay	Average cost
MS-DRG 064 Intracranial Hemorrhage or Cerebral Infarction with MCC – all cases	65,884	6.80	$11,305
MS-DRG 064 – all cases with principal diagnosis of hemorrhage, without V45.88	15,533	6.33	$11,722
MS-DRG 064 – all cases with principal diagnosis of hemorrhage + secondary diagnosis V45.88	28	4.96	$9,403
MS-DRG 064 – all cases with principal diagnosis of embolism or thrombosis	50,102	6.95	$11,170
MS-DRG 064 – all cases with principal diagnosis of embolism or thrombosis + secondary diagnosis V45.88	221	7.25	$12,651
Total cases in MS-DRG 064 of code V45.88	249		
MS-DRG 065 Intracranial Hemorrhage or Cerebral Infarction with MCC – all cases	96,274	4.75	$7,264
MS-DRG 065 – all cases with principal diagnosis of hemorrhage, without V45.88	14,085	5.11	$8,180
MS-DRG 065 – all cases with principal diagnosis of hemorrhage + secondary diagnosis V45.88	12	5.17	$10,229
MS-DRG 065 – all cases with principal diagnosis of embolism or thrombosis, without V45.88	81,741	4.69	$7,098
MS-DRG 065 – all cases with principal diagnosis of embolism or thrombosis + secondary diagnosis V45.88	436	5.06	$8,691
Total cases in MS-DRG 065 of code V45.88	448		
MS-DRG 066 Intracranial Hemorrhage or Cerebral Infarction with MCC – all cases	62,337	3.29	$5,291
MS-DRG 066 – all cases with principal diagnosis of hemorrhage, without V45.88	8,833	3.11	$5,164
MS-DRG 066– all cases with principal diagnosis of hemorrhage + secondary diagnosis V45.88	2	2.50	$5,495
MS-DRG 066 – all cases with principal diagnosis of embolism or thrombosis	53,294	3.32	$5,743
MS-DRG 066 – all cases with principal diagnosis of embolism or thrombosis + secondary diagnosis V45.88	208	3.36	$6,333
Total cases in MS-DRG 066 of code V45.88	210	--	--
MS-DRG 067 – Nonspecific CVA & Precerebral Occlusion without Infarct with MCC – all cases	1,831	5.24	$8,616

MS-DRG	Number of cases	Average length of stay	Average cost
MS-DRG 067 – Nonspecific CVA & Precerebral Occlusion without Infarct with MCC – all cases – + secondary diagnosis V45.88	0	0	0
MS-DRG 067 – Nonspecific CVA & Precerebral Occlusion without Infarct with MCC – all cases – without secondary diagnosis V45.88	1,831	5.24	$8,616
MS-DRG 068 – Nonspecific CVA & Precerebral Occlusion without Infarct without MCC – all cases	9,915	3.23	$5,540
MS-DRG 068 – Nonspecific CVA & Precerebral Occlusion without Infarct without MCC – all cases – + secondary diagnosis V45.88	2	4.00	$8,494
MS-DRG 068 – Nonspecific CVA & Precerebral Occlusion without Infarct without MCC – all cases – without secondary diagnosis V45.88	9,193	3.23	$5,539

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The analysis of MS–DRGs 067 and 068 above does not include a breakdown for cases of hemorrhage. That is because the principal diagnoses contained in these two MS–DRGs describe occlusion without infarct, by arterial site, except for diagnosis code 436 (Acute but ill-defined, cerebrovascular disease). The commenter believes diagnosis code 436 is often interpreted to be a "stroke, not otherwise specified" code and has been used to describe stroke events without a clear etiology, and wanted the analysis included for that reason.

When CMS created the MS–DRGs for use beginning October 1, 2007 (FY 2008), our purpose was, and remains, to accurately stratify groups of Medicare patients with varying levels of severity. Two of our major goals were to create DRGs that would more accurately reflect the severity of the cases assigned to them and to create groups that would have sufficient volume so that meaningful and stable payment weights could be developed. In designating an MS–DRG as one that could be subdivided into subgroups based on the presence of a CC or MCC, we developed a set of five criteria to facilitate our decision making process. The subgroup must meet all of the five criteria in order for division into CC or MCC splits to be considered. The entire discussion surrounding this process can be found in the FY 2008 IPPS/LTCH PPS final rule with comment period (72 FR 47169).

Even with additional review of the data, we are unable to justify either moving the "drip-and-ship" cases to higher weighted MS–DRGs or to consider creation of unique MS–DRGs for these cases. There is a paucity of data to substantiate such a change, whether due to underreporting of diagnosis code V45.88, or whether the tPA administered in another hospital was not documented in the receiving hospital's records, or whether the code was reported to CMS but was further down the list than the nine diagnosis codes considered for MS–DRG assignment. The differences in the average lengths of stay and the average costs represented in the above table are too small to warrant an assignment to the higher weighted MS–DRGs, and the differences in the length of stay and costs are not substantial enough to justify the creation of additional MS–DRGs. Therefore, for FY 2011, we are not making any changes to MS–DRGs 061, 062, 063, 064, 065, 066, 067, and 068; nor are we making changes to the MS–DRG assignment of diagnosis code V45.88.

We will continue to monitor these MS–DRGs and diagnosis code V45.88 in upcoming annual reviews of the IPPS.

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 FR 43785 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–DRGs": 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 in the FY 2010 IPPS/LTCH PPS proposed rule (75 FR 23900), 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).

For the FY 2011 proposed rule, 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
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

We stated in the proposed rule that if the cases identified by procedure code 88.59 were proposed to be reassigned from MS–DRGs 235 and 236 to MS–DRGs 233 and 234, they would be significantly overpaid. In addition, we indicated that 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, in the proposed rule, we indicated that 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 did not propose to make any MS–DRG modifications for cases reporting procedure code 88.59 for FY 2011.

Comment: Several commenters agreed with CMS' proposal to not make any MS–DRG modifications in FY 2011 for cases reporting procedure code 88.59. One commenter, the manufacturer, reported that they worked with a consulting group to conduct an analysis on a subset of MedPAR claims data that reported procedure code 88.59. According to the data presented, the consultant's methodology for the

analysis involved examining only cases from the facilities that reported procedure code 88.59, in any procedure code sequencing position, in each one of the four MS–DRGs previously discussed (233, 234, 235, or 236). The manufacturer asserted that results of the consultant's analysis varied significantly from the CMS data and that their data supported reassignment of cases reporting procedure code 88.59 from MS–DRGs 235 and 236 to MS–DRGs 233 and 234.

Response: We acknowledge the commenters who supported our proposal to not make any MS–DRG modifications for cases reporting procedure code 88.59 for FY 2011. In response to the manufacturer who worked with the consulting group, we point out that the process of evaluating MS–DRG reclassifications is not based on subsets of facility-specific data, but rather, as stated earlier in section II.B.2 of the preamble to this final rule, in deciding whether to make modifications to the MS–DRGs we consider 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. In addition, in evaluating resource costs, we consider both the absolute and percentage differences in average costs between the cases we select for review and the remainder of cases in the MS–DRG. As the manufacturer noted, the consultant's analysis submitted for consideration was based on a subset of facility-specific claims reporting code 88.59. Therefore, it is not comparable to the analysis conducted by CMS. While the consultant's analysis included cases that reported procedure code 88.59, it did not reflect the differences in comparison to MedPAR claims data, as the CMS analysis did, that are representative of the remaining Medicare patients grouped in the above mentioned relevant MS–DRGs.

In addition, the manufacturer also submitted the consultant's summary of observations from the analysis which stated two key points:

(1) The number of discharges they observed in the MedPAR data was slightly higher than the volumes reported in the proposed rule. They believed this may be the result of slightly different data files between what they examined and what CMS used. The volume differences are comparatively small.

(2) They were unable to account for differences in their cost calculation for cases reporting procedure code 88.59 and the CMS published results. Their hypothesis was that, because these represent a small number of cases, cost report differences may be playing a significant role in the calculation.

Currently, CMS' systems only process up to six procedure codes and, as the commenter stated, the consultant's methodology considered procedure code 88.59 in any sequencing position. Therefore, it is unclear how many cases may have been reported after the sixth position. Effective January 1, 2011, the HIPAA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update will become effective. The version 5010 format will allow facilities to report up to 25 diagnoses and 25 procedure codes, and CMS' systems will begin to process all 25 diagnosis and procedure codes. (Further detail regarding this issue is discussed in section II.G.11. of this final rule.).

Lastly, the manufacturer concluded that "the cost data continue to be unreliable due to the sample size and inherent limitations of cost reporting." We reiterate that the analysis conducted by the manufacturer and consultant were not comparable to the analysis conducted by CMS that examined cases reporting procedure code 88.59 against all cases in the specified MS–DRGs versus the consultant's analysis that only provided data on those facilities that are using the technology and their associated costs. Therefore, we are finalizing our proposal to not reassign 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.

As we indicated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23901), 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 indicated that we were unable to evaluate any data, other than that for procedure code 88.59, as shown in the tables above. We did not propose to create a new MS–DRG in FY 2011 for coronary bypass with intraoperative angiography, by any method.

Comment: Several commenters agreed with CMS' proposal to not create a new MS–DRG in FY 2011 for coronary bypass with intraoperative angiography, by any method. Another commenter, the manufacturer, acknowledged the limitations of the ICD–9–CM coding structure and the ability to currently only identify one method of intraoperative angiography. The manufacturer stated that the creation of a new ICD–9–CM procedure code to identify intraoperative angiography by conventional X-ray angiography would allow CMS to obtain accurate data on intraoperative or completion angiography by either method.

Response: We appreciate the commenter's support of our proposal to not create a new MS–DRG in FY 2011 for coronary bypass with intraoperative angiography, by any method. We also acknowledge the manufacturer's concern regarding the inability to identify intraoperative angiography by conventional X-ray angiography. As discussed previously (75 FR 23901) and in further detail below, proposals for creating a new procedure code must be submitted to the ICD–9–CM Coordination and Maintenance Committee for consideration.

c. New Procedure Codes

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23901), we indicated that, 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, in the FY 2011 proposed rule, we indicated that this topic would be further evaluated through the ICD–9–CM Coordination and Maintenance Committee meeting process.

Comment: Similar to comments made at the March 9–10, 2010 ICD–9–CM Coordination and Maintenance Committee meeting, one commenter, the manufacturer, stated that the resource utilization costs for a diagnostic cardiac catheterization, which is routinely performed in a catheterization laboratory may differ from those costs incurred for performing intraoperative completion angiography concomitant with a coronary artery bypass graft procedure in a surgical suite. However, the manufacturer noted that, regardless of the technology (IFVA or X-ray angiography), performance of intraoperative completion angiography in a surgical suite involves similar resources. The commenter further noted that an intraoperative completion angiography performed with X-ray angiography cannot be separately identified from a diagnostic cardiac catheterization due to the coding structure. According to the commenter, this scenario creates a payment incentive for physicians to select X-ray technology to perform a completion angiography, despite the known risks to patients associated with exposure to radiation because the code used to report X-ray angiography (cardiac catheterization) is recognized in the MS–DRG assignment. The commenter urged CMS to remove this incentive by ensuring that procedure code 88.59 will impact MS–DRG assignment in the same way that the code for X-ray angiography does.

Response: As stated above, requests for updates and changes to the procedure coding system are discussed through the ICD–9–CM Coordination and Maintenance Committee meeting process. At the March 9–10, 2010 meeting, a proposal was submitted by the manufacturer and presented. Details of the initial proposal regarding intraoperative angiography with coronary artery bypass graft discussed at the March 2010 ICD–9–CM Coordination and Maintenance Committee meeting along with the summary report of the meeting can be located at the following CMS Web site: *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*.

Currently, there is not a mechanism to analyze if both technologies utilize similar resources in the surgical suite as the manufacturer asserts since, as stated several times, the coding structure does not currently distinguish between intraoperative X-ray angiography and IFVA. Despite the inability to currently differentiate between the two technologies in an intraoperative setting, we disagree that physicians have a payment incentive to utilize X-ray angiography over IFVA to perform a completion angiography. The current MS–DRG assignments are based on claims data for the purposes of maintaining clinically coherence, accounting for patient's severity of illness, ensuring similar utilization of resources and complexity of services and are not formulated to provide incentives as the commenter indicated. We believe that physicians provide the most clinically appropriate, quality of care and make decisions with respect to the individual patient's needs and not subject patients to inherent risk.

In response to the manufacturer's request urging CMS to ensure that IFVA impacts the MS–DRG assignment in the same way as a cardiac catheterization currently does, as stated in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43787), it would be inappropriate to reassign cases reporting the use of IFVA to higher weighted MS–DRGs merely as an incentive for hospitals to invest in the IFVA technology.

As stated earlier, at the March 2010 meeting, an initial proposal was presented and, as a result, one aspect of the two-part proposal was finalized that involves an update to an existing code and the creation of a new code for IFVA. Effective October 1, 2010 (FY 2011), procedure code 88.59 has been revised to uniquely identify intraoperative coronary fluorescence vascular angiography and new code 17.71 has been created to identify noncoronary intraoperative fluorescence vascular angiography. We do not agree with the manufacturer's comment that these new code changes for FY 2011 will facilitates the MS–DRG case reassignment that the commenter proposed for procedure code 88.59 and believed was appropriate for policy. CMS does believe additional data are needed to fully evaluate the volume of cases and resources involved to perform intraoperative completion angiography using X-ray technology versus IFVA. Therefore, CMS is planning to discuss other options at a future ICD–9–CM Coordination and Maintenance Committee meeting.

In summary, we are finalizing our proposal not to make any changes to MS–DRGs 233, 234, 235 or 236 for cases reporting the use of procedure code 88.59.

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

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23901 and 23902), we indicated that we had received a request suggesting that we reassign 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.

In the FY 2011 proposed rule, we pointed 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 did not propose to reassign cases reporting procedure code 88.59 to MS–DRGs 228, 229, and 230 for FY 2011.

Comment: Several commenters supported the proposal not to reassign cases reporting procedure code 88.59 to MS–DRGs 228, 229, and 230.

Response: We appreciate the commenters' support.

We are finalizing our proposal to not 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.

As indicated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23902), in response to the commenter's request, we pointed 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.

For the FY 2011 IPPS/LTCH PPS proposed rule, 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 2,011 cases 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, in the proposed rule, we indicated that we did not believe it was 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, we indicated that 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 invited the public to submit comments on our proposal not to make any MS–DRG modifications to cases involving the use of gastrointestinal stents for FY 2011.

Comment: Several commenters in general supported CMS' proposal not to make any MS–DRG modifications involving the use of gastrointestinal stents for FY 2011. One commenter expressed appreciation for CMS' efforts to consider its request to create a new series of MS–DRGs for gastrointestinal stent placement cases. The commenter acknowledged the lack of specific ICD–9–CM procedure codes for colonic and duodenal stent placement in the data and CMS' practice of not using revenue codes to help distinguish between different types of procedures. The commenter agreed that the lack of specific codes and not using revenue codes in the MS–DRG grouping logic precludes CMS' ability to implement the requested MS–DRG modifications for gastrointestinal stents for FY 2011. The commenter indicated that it will continue to monitor these cases in future years and, if appropriate, request the creation of new MS–DRGs.

Response: We agree with the commenters that our data and claims analysis support our proposal to not make any MS–DRG modifications to cases involving the use of gastrointestinal stents for FY 2011. Therefore, we are finalizing our proposal to not make any MS–DRG modifications 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, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23903), we stated that 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 did not propose to reassign cases reporting procedure code 84.82 from MS–DRG 490 to MS–DRG 460 for FY 2011.

Comment: Several commenters supported CMS' proposal not to reassign cases reporting procedure code 84.82 from MS–DRG 490 to MS–DRG 460 for FY 2011. One commenter, the manufacturer, stated that they conducted a clinical comparison of Dynesys® as well as an analysis of charges and costs associated with MS–DRGs 490 and 460, specifically procedure codes 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), and 81.08 (Lumbar and lumbosacral fusion, posterior technique). According to the manufacturer, the analysis demonstrated that the resource utilization of Dynesys® as a nonfusion device is similar to that of fusion and is greater than that of other procedures grouped in MS–DRG 490.

Response: We appreciate the manufacturer's analysis. As stated previously, and as the manufacturer stated in its comments, the FDA has not yet approved the Post-Market Approval (PMA) application to expand the indication of Dynesys® for use as a non-fusion device. Dynesys® is currently approved as an *adjunct* to spinal fusion; therefore, when reported correctly, cases utilizing the Dynesys® technology are appropriately assigned to the fusion MS–DRGs. We will continue to monitor the resource utilization of procedure codes 84.82 and 81.08 to determine if future MS–DRG reassignments or new MS–DRGs are warranted. For FY 2011, we are finalizing our proposal not to reassign cases with procedure code 84.82 from MS–DRG 490 to MS–DRG 460.

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

As discussed in the FY 2011 IPPS/ LTCH PPS proposed rule (75 FR 23903), 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." For the FY 2011 proposed rule, 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 indicated that we believed the request has merit in identifying neonate cases appropriately. Therefore, for FY 2011, we proposed to add discharge status code 05 to the MS–DRG GROUPER logic for MS–DRG 789.

Comment: Some commenters supported the proposed change to the MS–DRG GROUPER logic for discharge status 05. A few commenters commended CMS for responding to industry requests related to MDC 15, especially in light of the limited impact on the Medicare population while acknowledging that other payers also utilize the MS–DRG classification system. One commenter recommended adding the logic for discharge status code 05 to the MS–DRG GROUPER logic for all newborn cases assigned to MS–DRGs: 790 (Extreme Immaturity or Respiratory Distress Syndrome, Neonate), 791 (Prematurity with Major Problems), 792 (Prematurity without Major Problems), 793 (Full Term Neonate with Major Problems), 794 (Neonate with Other Significant Problems), and 795 so that these cases may be appropriately grouped to the MS–DRG 789 for transferred neonates.

Response: We appreciate the support of the commenters. To clarify our proposed policy change, we are adding discharge status code 05 to the MS–DRG GROUPER logic for assigning cases to MS–DRG 789. This change will result in any case identified with discharge status 05, which would have normally been assigned to MS–DRGs 790 through 795, being reassigned to MS–DRG 789, as the commenter recommended.

After consideration of the public comments we received, we contend that this logic change has merit and, therefore, are adopting it as final for FY 2011. All newborn cases assigned to MS–DRGs 790 through 795 and indentified with discharge status 05 will be reassigned to MS–DRG 789 for transferred neonates.

b. Vaccinations of Newborns

As discussed in the FY 2011 IPPS/ LTCH PPS proposed rule (75 FR 23903), 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.

For the FY 2011 proposed rule, 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, as we indicated in the FY 2011 proposed rule, 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 the proposed rule, for FY 2011, we proposed to remove code V64.05 from MS–DRG 794 and add this code to the only secondary diagnosis list for MS–DRG 795.

Comment: Commenters supported this proposed change.

Response: We appreciate the commenters support. As stated above, we believe that the assignment of code V64.05 to MS–DRG 795 is appropriate.

After consideration of the public comments we received, we are adopting our proposal to remove code V64.05 from MS–DRG 794 and to add it to the only secondary diagnosis list for MS–DRG 795 as final for FY 2011.

7. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this final rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a MS–DRG. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23903), we indicated that we intended to make the following changes to the MCE edits and invited public input on whether or not we should do so:

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

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

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

Comment: A number of commenters opposed the proposed change because they believed that this sequencing change in the order of reported codes would eliminate Medicare coverage for the condition of gastroparesis.

Response: The commenters erroneously believed that this sequencing change in the order of reported codes would eliminate Medicare coverage for the condition of gastroparesis. Therefore, we are taking the opportunity in this final rule to clarify that at no time did we intend to withdraw coverage for gastroparesis. We believe that many commenters mistakenly assumed that if diagnosis code 536.3 were not permitted to be in the principal diagnosis position, it would become a noncovered condition by Medicare. This is not CMS' intent, nor would it have been the result of our proposed change. As one commenter stated: "The effect of the proposed edit would be that idiopathic gastroparesis * * * could not be sequenced as a principal diagnosis. We recognize that an inconsistency currently exists between the MCE and the 'code first underlying disease' associated with [code] 536.3. We understand the issue is not with the MCE, but rather the note."

We agree with the commenters and with the medical community that diagnosis code 536.3 should not be included in the MCE's Unacceptable Principal Diagnosis Edit, and hereby withdraw our suggestion to put it on that list. Diagnosis code 536.3 will not be added to the MCE in FY 2011.

We understand that the matter of the "code first" note will be addressed by the ICD–9–CM Coordination & Maintenance Committee in September 2010.

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, in the FY 2011 proposed rule, we indicated that we intended to delete the entire Open Biopsy Check edit from the MCE, which meant 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)

We did not receive any public comments regarding the proposal to delete the Open Biopsy Check edit from the MCE. Therefore, because there were no objections to the proposal, we are deleting the Open Biopsy Check edit from the MCE. The edit containing the codes listed above will be removed, effective for October 1, 2010 (FY 2011).

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 the FY 2011 IPPS/LTCH PPS proposed rule, in which we proposed to add code 251.3 (Postsurgical hypoinsulinemia) to those MS–DRGs, we indicated in that FY 2011 proposed rule that we intended to add procedure code 251.3 to the list of acceptable principal or secondary diagnosis codes in the MCE.

We did not receive any public comments on our proposal to add procedure code 251.3 to the list of acceptable principal or secondary diagnosis codes in the MCE. Therefore, because there were no objections to this proposal, we are adding procedure code 251.3 (Postsurgical hypoinsulinemia) to the MCE in the list of acceptable principal or secondary codes associated with procedure codes 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas).

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.

As we proposed, based on the changes that we are making for FY 2011, as discussed in section II.C.2. of this preamble, we are revising 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 reordering new MS–DRG 014 (Allogeneic Bone Marrow Transplant) above MS–DRG 007 (Lung Transplant); and new MS–DRG 015 (Autologous Bone Marrow Transplant) above MS–DRG 010 (Pancreas Transplant).

In MDC 10, we are reordering 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).

Comment: Commenters generally supported our proposals without any objections.

Response: Based on the test of the proposed revisions using the March 2010 update of the FY 2009 MedPAR file and the revised GROUPER software, we found that the revisions are still supported by the data. Therefore, we are incorporating the proposed revisions to the surgical hierarchy as final for FY 2011.

9. Complications or Comorbidity (CC) Exclusions List

a. Background

As indicated earlier in the preamble of this final 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. 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) Limited Revisions Based on Changes to the ICD–9–CM Diagnosis Codes

For FY 2011, as we proposed, we are making limited revisions to the CC Exclusions List 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 final rule for a discussion of ICD–9–CM changes.) We are making 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:

- 731.3 (Major osseous defects)

[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.

- 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)

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that we believed these comments were outside the scope of the proposals in the FY 2010 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)

For the FY 2011 IPPS/LTCH PPS proposed rule, 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, as we proposed, we are not changing 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.

For the FY 2011 proposed rule, 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 summarizes 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 for FY 2011. 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. For the FY 2011 proposed rule, we did not recommend any change in the severity classification of diagnosis code V85.4. We proposed to retain it as a CC for FY 2011. We welcomed public comments on our proposal not to change the severity levels of the diagnosis codes mentioned above.

Comment: Several commenters in general supported the proposal not to change the following codes from a non-CC to a CC or MCC based on our data and clinical analysis: 278.00; 278.01; 278.02; 731.3; V85.35; V85.36; V85.37; V85.38; and V85.39.

The commenters also supported our proposal not to change code V85.40 from a CC to an MCC.

One commenter stated that it understood that the request to change the severity level for the obesity related codes was not supported by the current hospital claim data. The commenter expressed appreciation for CMS' consideration of its recommendation. However, the commenter expressed concerns that hospitals may not be fully reporting codes that describe obesity, and, therefore, all resources associated with obesity related cases may not be included in the hospital claims data. The commenter requested that CMS actively encourage hospitals to report codes that more fully describe obesity and its related conditions. The commenter stated that if hospitals increased their reporting of obesity related conditions, our national data would be more accurate and would more fully reflect hospital resource use associated with these patients.

Another commenter also acknowledged that the data did not support a change in the severity level for the obesity related codes. This commenter also expressed that hospitals may be underreporting obesity cases, and requested that hospitals be encouraged to more fully and accurately code and report these conditions. Once a more complete data set is available to describe these patients, the commenter recommended that the issue be reviewed again.

Response: We agree with the commenters that our data and clinical analysis support our proposal not to change the severity level for the obesity related codes. We appreciate the commenters' statement about our consideration and review of this issue. We agree that it is important to provide clear documentation and accurate coding for all patient diagnoses and conditions, including obesity related conditions. As discussed in section II.G.11.c. of this preamble, we are expanding the number of diagnosis and procedure codes processed so that more codes are available to describe each patient's hospitalization. The clinical data and the comments received support our recommendation not to change the severity levels for the obesity related codes. Therefore, we are finalizing our proposal to continue classifying the following codes as non-CCs for FY 2011.

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

We are also finalizing our proposal to continue classifying the following code as a CC for FY 2011.

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

(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. For the FY 2011 IPPS/LTCH PPS proposed rule, 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 did not propose 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.

Comment: Several commenters in general supported CMS' proposal not to change diagnosis code 331.0 from a non-CC to a CC for FY 2011. They stated that the data supported this decision. One commenter stated that the analysis provided by CMS supports the proposal that diagnosis code 331.0 should continue to be a non-CC. The commenter suggested that this issue be revisited after CMS begins processing 25 codes instead of the current limitation of 9 diagnosis codes.

Response: We agree with the commenters that our data support our proposal not to change diagnosis code 331.0 from a non-CC to a CC for FY 2011. Therefore, we are finalizing our proposal to continue classifying diagnosis code 331.0 as a non-CC for FY 2011. We will revisit the severity level classification of diagnosis code 331.0 once we begin processing claims using the increase in the number of diagnosis codes to 25.

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

We received a request to reclassify the diagnosis code, which captures acute renal failure, 584.9 (Acute kidney 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. 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 kidney 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.

For the FY 2011 IPPS/LTCH PPS proposed rule, 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 proposed to change the severity level for diagnosis code 584.9 from a MCC to a CC for FY 2011.

Comment: Most commenters opposed our proposal to change diagnosis code 584.9 (Acute kidney failure, unspecified) from an MCC to a CC. However, one commenter supported the proposal to change the severity level classification of acute renal failure cases from an MCC to a CC. The commenter stated that there has been an increased reporting of acute renal failure which is primarily due to increased physician education by clinical documentation improvement programs. The commenter further stated that the statistical analysis offered in the proposed rule was sufficient to support this change.

Response: We agree that the claims data support our proposal to change diagnosis code 584.9 from an MCC to a CC. We respond to the specific comments opposing our proposed changes in the following comments and responses.

Comment: Several commenters suggested that the introduction of the terminology of acute kidney injury may have added to the inconsistent classification of the disease process. One commenter stated that, in 2004, the Acute Dialysis Quality Initiative work group provided a definition and classification system for acute renal failure, described by the acronym RIFLE (Risk of renal dysfunction, Injury to the kidney, Failure or Loss of kidney function, and End-stage kidney disease). The commenter stated that clinical researchers have since applied the RIFLE system to the clinical evaluation of acute kidney injury. Several commenters stated that the FY 2009 update to the coding classification system, which classifies acute kidney injury and acute renal failure with the same code, may be diluting the patient mix. The commenters stated that inconsistency in the application of diagnosis code 584.9 results in dilution of the data and an inaccurate reflection of the severity level for acute renal failure.

Another commenter stated that claims data on diagnosis code 584.9 may be flawed due to the variable terminology used by physicians and changes in the ICD–9–CM classification. This commenter stated that physicians often use the terms "acute renal insufficiency" and "acute renal failure" interchangeably, and that this results in cases of acute renal insufficiency being classified as acute renal failure. The commenter also stated that physicians often use the term "acute kidney injury" to mean either acute renal insufficiency or acute renal failure, and that the term "acute kidney injury" is indexed in ICD–9–CM to diagnosis code 584.9. Therefore, the commenter stated that cases of acute kidney injury are also being classified as acute renal failure. The commenter stated that these inconsistencies result in diagnosis code 584.9 capturing a mix of cases, including both acute renal insufficiency as well as true acute renal failure cases, and that this has diluted national data for diagnosis code 584.9 and is an inaccurate reflection of the severity level for acute renal failure. The commenters recommended that diagnosis code 584.9 remain an MCC while CMS works on ways to revise the codes or improve documentation guidelines.

Response: We agree that diagnosis code 584.9 captures a range of severity levels. Patients are not consistently at the highest severity level as shown by our claims data. As discussed above, our claims data show that patients with this code as a secondary diagnosis are similar to those who are at a CC level. We do not believe it is appropriate to defer a decision on reclassification of the severity level of diagnosis code 584.9 until future coding or guideline modifications can be considered because our claims data clearly support the proposed change. Should a new range of codes be developed, we will consider what severity levels should be applied to each new code and include this analysis as part of future rulemaking.

Comment: One commenter stated that the definition of conditions assigned to diagnosis code 584.9 is inadequate as it encompasses patients with both small and large elevations of creatinine that still meet the definition of acute kidney injury. Furthermore, the commenter pointed out that diagnosis code 584.9 does not identify severe cases of renal failure requiring dialysis. However, the commenter opposed changing diagnosis code 584.9 from an MCC to a CC as it would penalize those institutions treating more severe cases of renal failure. The commenter indicated its plans to contact the National Center for Health Statistics to request that fifth digits be added to diagnosis code 584.9 to distinguish those in various stages of renal failure. Other commenters also agreed that diagnosis code 584.9 was vague and suggested that the code be subdivided to add additional information on the stages of the renal function. The commenters suggested using existing standards from the Acute Kidney Injury Network or the National Kidney Foundation to develop stages for kidney injury that could be captured with the new codes.

Another commenter agreed that the diagnosis of acute renal failure should not be used to describe mild dehydration and renal insufficiency when only minor lab abnormalities are present. The commenter believed that criteria were needed to better define the stages of acute renal failure. The commenter stated that appropriate guidelines were needed for both physicians and coders who are attempting to differentiate between a mildly dehydrated patient and one with true acute renal failure. Until such time as these documentation guidelines are developed, the commenter asked that

diagnosis code 584.9 not be changed from an MCC to a CC.

Response: We agree that diagnosis code 584.9 captures a wide range of severity levels. We also agree that the use of this code does not mean that the patient's renal capacity is so impaired as to require renal dialysis. As stated earlier, our data indicate that most of these cases are at a CC severity level, not an MCC. As stated earlier, we do not believe it is appropriate to defer a decision on reclassification of the severity level of diagnosis code 584.9 until future coding or guideline modifications can be considered. Should a new range of codes be developed, we will consider what severity levels should be applied to each new code and include this within future rulemaking.

Comment: Several commenters objected to a change of severity levels for diagnosis code 584.9 from an MCC to a CC because of the financial impact the change would have on their hospitals. Several hospitals stated that this change would reduce their annual Medicare payments by $1.0 to $3.6 million per year. Other commenters stated that this change could lead to a reduction of 2 percent or more in total Medicare payments to their facilities. The commenters acknowledged that the code does not consistently capture patients at the highest severity level and that there was no clear convention among clinicians for documenting acute renal insufficiency versus acute renal failure. The commenters asked that the change not be made because of the payment impact on their hospitals.

Response: We agree that diagnosis code 584.9 captures patients who are not consistently at the highest severity level. Classifying these patients at the highest severity level greatly distorts our national data. It gives the impression that a large number of patients have an MCC severity level when they may in fact have only minor renal symptoms. Our data support that patients with diagnosis code 584.9 are more appropriately classified at the CC severity level. These acute renal failure patients captured with this code do not utilize the resources of other conditions on the MCC list. We believe the data support changing the code from an MCC to a CC. We believe our claims data show that this change will lead to more accurate payment, even if it does reduce some hospital payments. We do not believe it is appropriate to inflate payments for hospitals that report a higher incidence of this code, yet are treating patients with a lower severity level.

Comment: Other commenters who disagreed with the proposed change from an MCC to a CC, acknowledged that this unspecified code captures a range of severity levels from those patients with only a minimal elevation in serum creatinine or simple dehydration to those patients who are actually in acute renal failure. Some of the commenters stated that, while the code may currently capture patients with low severity levels, the patients still need treatment and monitoring to prevent any worsening in their conditions. The commenters also acknowledged that there is no clear convention among clinicians for documenting acute renal insufficiency versus acute renal failure. The commenters stated that this has been a problematic area on which there have been consensus conferences and publications from a variety of quality and renal organizations. The commenters stated that additional work was needed to develop a clear consensus for documenting acute renal failure. The commenters urged CMS to pursue greater standardization for the clinical documentation of acute renal failure. Until such time as the clinical documentation improves, the commenters recommended that CMS continue to classify diagnosis code 584.9 as an MCC.

Response: We agree that there is not a consistent use of the term acute renal failure. As mentioned earlier, this term has been used to describe a wide range of severity levels. However, our claims data show that the term is being used predominately to describe those patients who are not at the highest severity level. The patients are more like others with a CC severity level. We do not believe that it is appropriate for CMS to wait for a consensus to build about how to use and document the term acute renal failure. We believe it is more appropriate to base our decision on current claims data and clinical review. Regardless of the different uses of the term "acute renal failure" and the inclusion of a wide range of severity levels, the current data show that the code is more properly a CC and not an MCC. As mentioned by a number of commenters, the term "acute renal failure" is being used for a wide variety of patients, most of which do not have a high severity level. We also point out that we proposed reclassifying only the unspecified acute renal failure code from an MCC to a CC. We are leaving the more precise acute renal failure codes as MCCs. For instance, these more precise acute renal failure codes will remain on the MCC list:

- 584.5 (Acute kidney failure with lesion of tubular necrosis);
- 584.6 (Acute kidney failure with lesion of renal cortical necrosis);
- 584.7 (Acute kidney failure with lesion of renal medullary [papillary] necrosis); and
- 584.8 (Acute kidney failure with other specified pathological lesion in kidney).

We proposed to remove only the code for an unspecified type of acute kidney failure from the MCC list and to add it to the CC list. Our data support this reclassification.

After consideration of the public comments we received, we are finalizing our proposal to change diagnosis code 584.9 (Acute kidney failure, unspecified) from an MCC to a CC.

Comment: One commenter asked that CMS also examine whether the following encephalopathy codes should be removed from the MCC list. The commenter stated that claims analysis may show a justification for removing these codes from the MCC list.

- 348.30 Encephalopathy, unspecified
- 348.31 Metabolic encephalopathy
- 348.39 Other encephalopathy
- 349.82 Toxic encephalopathy

Response: We believe this comment is outside the scope of the FY 2011 IPPS/LTCH PPS proposed rule. We did not propose to change the severity level classification for any of the encephalopathy codes. We will examine this issue as part of next year's proposed rule. Therefore, we are not making any changes to the severity level classifications of the encephalopathy codes mentions above.

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 final rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H in the Addendum to this final 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 final rule, we are providing the following summaries of those MCC and CC changes.

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

Code	Description
488.01	Influenza due to identified avian influenza virus with pneumonia
488.11	Influenza due to identified novel H1N1 influenza virus with pneumonia

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
278.03	Obesity hypoventilation syndrome
488.02	Influenza due to identified avian influenza virus with other respiratory manifestations
488.09	Influenza due to identified avian influenza virus with other manifestations
584.9	Acute kidney failure, unspecified
780.33	Post traumatic seizures
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 includes the final FY 2011 MS–DRG changes, will be available in CD only for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303, or by obtaining an order form at the Web site: *http://www.3MHIS.com.* Please specify the revision or revisions requested.

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 did not propose to change the procedures assigned among these MS–DRGs.

We did not receive any public comments on our proposal and, therefore, are adopting it as final.

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

[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).

evident in MS–DRGs 987 through 989. There were a total of 1,601 cases across 17 MDCs and, again, the cases did not 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 did not propose 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.

We did not receive any public comments on our proposal and, therefore, are adopting it as final.

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 did not propose to move any procedure codes among these MS–DRGs.

We did not receive any public comments on our proposal and, therefore, are adopting it as final.

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 did not propose to add any diagnosis or procedure codes to MDCs for FY 2011.

We did not receive any public comments on our proposal and, therefore, are adopting it as final.

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 final 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 final 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 the FY 2011 IPPS/LTCH PPS proposed rule are included in Tables 6A through 6F of the Addendum to this final rule and are 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 final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23911), we solicited comments on the proposed classification of these new codes, which were shown in Tables 6A and 6B of the Addendum to the proposed rule.

Comment: A few commenters supported our proposals. One commenter, representing one of the national hospital associations, recommended that the new codes 488.01 (Influenza due to identified avian influenza virus with pneumonia) and 488.11 (Influenza due to identified novel H1N1 influenza virus with pneumonia) be assigned to the pneumonia MS–DRGs to be consistent with the MS–DRG definitions and classification of diagnosis code 487.0 (Influenza with pneumonia).

Response: We agree with the commenters. Therefore, both codes 488.01 and 488.11 will be assigned to MS–DRGs 193 through 195 (Simple Pneumonia with Pleurisy With MCC, Simple Pneumonia with Pleurisy With CC, and Simple Pneumonia with Pleurisy Without CC/MCC, respectively) as reflected in Table 6A of this final rule.

Comment: The same commenter representing one of the hospital associations also questioned the CC designation for two new codes: 780.33 (Post traumatic seizures) and 278.03 (Obesity hypoventilation syndrome). In the proposed rule (75 FR 24207 through 24208), both codes were listed as non-CCs in Table 6A. The commenter pointed out that specific seizures (convulsions) codes such as 780.31 (Febrile convulsion (simple), unspecified) and 780.32 (Complex febrile convulsions) are classified as a CC and to be consistent within the classification system, code 780.33 should also be classified as a CC.

The commenter recommended further analysis for code 278.03 (Obesity hypoventilation syndrome) to determine if this condition meets the definition of a CC. The commenter pointed out that obesity hypoventilation syndrome is a condition where overweight patients cannot breathe appropriately resulting in low blood oxygen levels and high blood carbon dioxide levels. This condition puts a strain on the heart and lungs and may eventually lead to a more serious condition such as heart failure or respiratory failure. This condition would have to be closely monitored while the patient is in the hospital and may require respiratory treatment such as CPAP, BIPAP, or even mechanical ventilation depending on the severity of the condition. Such services involve intensive monitoring where, for example, in an intensive care unit, expensive and technically complex services or extensive care requiring a greater number of caregivers is required.

Response: Our medical advisors agree with the commenter's assessment that both codes should be classified as CCs. Therefore, we are amending the proposed non-CC designation for both codes 788.03 and 278.03 and classifying them as CCs in Table 6A. These changes are reflected in Table 6A in this final rule.

Comment: Several commenters addressed the MS–DRG placement of new procedure code 35.97 (Percutaneous mitral valve repair with implant) that was created for use beginning on October 1, 2010. The commenters urged CMS to assign this code to the same MS–DRG as open surgery so that higher payment would result.

Response: In addition to the MitraClip® device not yet being FDA approved, we have no claims data on which to evaluate such a MS–DRG assignment. However, the most important concept for denying these requests is that the MitraClip® device is delivered percutaneously. To assign this percutaneous procedure to MS–DRGs utilizing an open approach would not conform to the structure of the MS–DRGs, and disregards the concept of clinical coherence. We have no evidence-based data with which to justify any other MS–DRG assignment than those where the current percutaneous valve procedures are now assigned. Therefore, procedure code 35.97 is assigned to MS–DRGs 246, 247, 248, 249, 250, and 251.

Comment: Two comments urged CMS to assign new procedure code 37.37 (Excision or destruction of other lesion or tissue of heart, thoracoscopic approach) to MS–DRGs 228, 229, and 230 (Other Cardiothoracic Procedure with MCC, with CC, and without CC/MCC, respectively).

Response: CMS' practice has been, where practicable, to assign new ICD–9–CM codes to the same MS–DRG(s) as their predecessor codes. For this reason, procedure code 37.37 has been assigned to MS–DRGs 228, 229, and 230, as described above.

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

this final rule includes revised procedure code titles for FY 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 were finalized by May 2010 are included in Tables 6A through 6F in the Addendum to this final rule.

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

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

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

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

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April l, 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 that 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23913), we solicited additional input on this subject, especially in light of the requirements on hospitals for meaningful use of electronic health records. We welcomed 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 welcomed 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.

Comment: A number of commenters supported the recommendation that the last regular update to ICD–9–CM and ICD–10–CM/PCS be implemented on October 1, 2011, with only limited code updates to both ICD–9–CM and ICD–10–CM/PCS on October 1, 2012, to capture new technologies and procedures as well as new diseases. Commenters stated that successful implementation of ICD–10 will require significant planning, education, and systems modifications. Continuing regular updates to ICD–9–CM and ICD–10–CM/PCS would make the implementation of these new coding systems more costly and complex. The commenters recommended that updates occurring on October 1, 2012, be limited to proposals for urgently needed codes. They stated that such proposals should make a "clear and convincing" case to the ICD–9–CM Coordination and Maintenance Committee, including public comment as to why the proposal cannot wait for the next regularly scheduled updates. An example of the emergence of a new disease such as H1N1 influenzas was provided.

Several commenters who supported the limited freeze stated that, by accommodating the process for the capture of new technologies and disease during this period, CMS is not only in compliance with section 503(a) of Public Law 108–173 requirements for new technology, but also anticipates that new diagnosis codes may be needed to capture new diseases, as we have seen with the Avian and H1N1 influenzas. The commenters called this a thoughtful approach which should allow the freeze of code sets while still accommodating new codes for new technologies and procedures as well as urgent needs to capture new diseases. Several commenters also stated that most practicing physicians and their staff have not had sufficient opportunity to become familiar with ICD–10–CM. They believed that this freeze will allow physicians and physician specialty groups a better opportunity to become familiar with the codes common to their specialty prior to the implementation of ICD–10. Other comments who supported the recommendations for a limited code freeze recommended that CMS and CDC develop strict criteria that a code proposal must meet in order to qualify for the limited update during the freeze period.

Several commenters recommended that there be no updates to ICD–10–CM/PCS on October 1, 2013, unless absolutely necessary. They indicated that an example of an urgent need was that of a pandemic that could not be otherwise reported with existing codes. The commenters stated that they understood the statutory requirements for add-on payments for new technology under the inpatient payment system, and urged CMS to consider alternative solutions to recognize such new technologies. Other commenters opposed any ICD–10 code updates on October 1, 2013. The commenters stated that a total freeze was needed on October 1, 2013, to enable users of the classification system the opportunity to prepare for ICD–10.

One commenter who strongly supported the limited freeze offered an example of the possible impact of not pursuing a code freeze would have on its organization. This organization is currently working with clients to complete the necessary software updates for the adoption of ICD–10 by early next year. Based on its analysis, the work is not confined to systems but also involves coding and billing activities for healthcare claims. The commenter stated that there would be an impact on physician documentation, problem lists, decision support, laboratory, emergency department, radiology, nursing, scheduling, registration management, and other internal systems. The commenter opined that, by continuing regular code updates without a freeze, they would have to rework activities and spend cycle time doing maintenance updates to software and content updates they had already performed to include additional annual code updates. The ICD–10 updates they make will need to be tested and maintenance activities performed to build the necessary reference data to support production adoption of ICD–10.

One commenter strongly opposed the partial freeze for FY 2012. The

commenter stated that accurate, specific code assignment is a prerequisite for accurate physician and hospital profiling and value-based purchasing. The commenter stated that ICD–10–CM is an imperfect system and that refinements to ICD–9–CM should be carried over to ICD–10 prior to its implementation date of October 1, 2013. The commenter urged CMS to continue to work on refining ICD–10. Another commenter opposed any freeze of ICD–9–CM or ICD–10 codes. The commenter stated that codes should continue to be updated as usual each year so that physician and hospital efficiency can be more accurately measured with accurate codes.

Several commenters supported the limited freeze, but requested that the last regular code updates be on October 1, 2012, instead of 2011. The commenters stated that a 3-year freeze from October 1, 2011 through October 1, 2014 was overly long.

Response: We will review all comments received on the partial freeze as part of the ICD–9–CM Coordination and Maintenance Committee process as well as these additional comments received and summarized above. A final decision on whether or not there will be a partial code freeze will be announced at the September 15–16, 2010 ICD–9–CM Coordination and Maintenance Committee. An agenda for this meeting will be posted on the CMS Web site by mid-August 2010 at *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.*

We believe that this advance notice of a partial code freeze provides 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.

Comment: Several commenters commended CMS on its plans to accept and process up to 25 diagnoses and 25 procedures on hospital inpatient claims submitted on the 5010 format beginning January 1, 2011. One commenter expressed appreciation for CMS' recognition that a complete picture of patients' clinical conditions and procedures is necessary in order to accurately measure quality, analyze outcomes, assess severity of illness, and determine reimbursement.

Response: We appreciate the support for our plan to accept and process up to 25 diagnoses and 25 procedures on hospital inpatient claims submitted on the 5010 format beginning January 1, 2011. We will keep the providers updated on our progress in this activity.

ICD–10 MS–DRGs

We received comments on the creation of the ICD–10 version of the MS–DRGs, which will be implemented on October 1, 2013 (FY 2014) when we implement the reporting of ICD–10 codes. While we did not propose an ICD–10 version of the MS–DRGs, CMS has been actively involved in converting our current MS–DRGs from ICD–9–CM codes to ICD–10 codes and sharing this information through the ICD–9–CM Coordination and Maintenance Committee. CMS undertook this early conversion project to assist other payers and providers in understanding how to go about their own conversion projects. We posted ICD–10 MS–DRGs based on V26.0 (FY 2009) of the MS–DRGs. We also posted a paper that describes how CMS went about completing this project and suggestions for others to follow. All of this information can be found on our Web site at: *http://www.cms.gov/ICD10/*

17_ICD10_MS_DRG_Conversion_Project.asp. We will continue to keep the public updated on our maintenance efforts for ICD–10–CM and ICD–10–PCS coding systems as well as the General Equivalence Mappings that assist in conversion through the ICD–9–CM Coordination and Maintenance Committee. Information on these committee meetings can be found at: *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.*

Comment: Several commenters recommended that the ICD–10 MS–DRG GROUPER logic be available no later than the FY 2013 rulemaking period, with an extended public comment period in order to allow providers sufficient time to analyze and model the proposed MS–DRG groupings prior to its implementation on October 1, 2013.

Response: CMS initiated early efforts to convert the MS–DRGs from ICD–9–CM codes to ICD–10 codes. As discussed earlier, the public was informed of this project through the ICD–9–CM Coordination and Maintenance Committee. Summary reports of those meetings where this ICD–10 conversion of MS–DRGs took place can be found at *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* Currently, we have Version 26.0 of the ICD–10 MS–DRGs posted for public review. During FY 2011, we will post Version 28.0 of the ICD–10 MS–DRGS based on the FY 2011 MS–DRGs (Version 28.0) that we are finalizing in this final rule. This ICD–10 MS–DRG Version 28.0 will also include the CC Exclusion List, which was not posted with Version 26.0. We will be discussing this update at the September 15–16, 2010 ICD–9–CM Coordination and Maintenance Committee Meeting. A complete agenda for this meeting will be posted in mid-August 2010 at: *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* The registration site for the meeting will open on August 13, 2010. We will continue to work with the public to explain how we are approaching the conversion of MS–DRGs to ICD–10 and will post drafts of updates as they are developed for public review. The final version of the ICD–10 MS–DRGs to be implemented in FY 2014 will be subject to notice and comment rulemaking. In the meantime, we will provide extensive and detailed information on this activity through the ICD–9–CM Coordination and Maintenance Committee.

12. Other Issues Not Addressed in the Proposed Rule

We received a number of public comments on issues that were not within the scope of the proposals in the FY 2011 IPPS/LTCH PPS proposed rule.

a. Rechargeable Dual Array Deep Brain Stimulation System

We received a public comment requesting that CMS assign the combination of procedure codes representing rechargeable systems for deep brain stimulation therapy, code 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)), and code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) to MS–DRGs 023 and 024 (Craniotomy with Major Device Implant/Acute Complex CNS PDX with MCC or Chemo Implant and Craniotomy with Major Device Implant/Acute Complex CNS PDX without MCC, respectively). The commenter stated that this would allow all full system dual array deep brain stimulation cases to be appropriately grouped to the same MS–DRGs. The commenter stated that the procedures to implant the rechargeable and nonrechargeable dual array systems are similar clinically and with respect to resource utilization. Currently, codes 02.93 and 86.98 are assigned to MS–DRGs 025 through 027 (Craniotomy and Endovascular Intracranial Procedures with MCC, Craniotomy and Endovascular Intracranial Procedures with CC, and Craniotomy and Endovascular Intracranial Procedures without MCC/CC, respectively).

This comment is outside the scope of the FY 2011 IPPS/LTCH PPS proposed rule, as we did not propose any changes to MS–DRGs 023 and 024 for rechargeable systems for deep brain stimulation therapy. Therefore, we are not addressing this issue for FY 2011. As we stated in FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23864), 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 subject to public review and comment.

b. IntraOperative Electron RadioTherapy (IOERT)

We received a public comment requesting that CMS update the MS–DRG mapping assignments for procedure code 92.41 (Intra-operative electron radiation therapy) to ensure the cost of this technology is captured in each MS–DRG involving tumor removal in the rectum, head/neck, pancreas, lung, genitourinary, soft tissue, and breast. IntraOperative Electron RadioTherapy (IOERT) is the direct application of radiation to a tumor and/or tumor bed while the patient is undergoing surgery for cancer. Currently, this code is not assigned to a specific MS–DRG.

This comment is outside the scope of the FY 2011 IPPS/LTCH PPS proposed rule, as we did not propose any changes to the MS–DRG for IOERT. We refer the commenter to section II.B.2 of the proposed rule (75 FR 23864) where we discuss the timeline for submission of comments about MS–DRG classifications.

c. Brachytherapy

We received a public comment requesting that CMS assign procedure code 92.27 (Implantation or insertion of radioactive elements) to various MS–DRGs where the use of brachytherapy sources has been expanded. In addition, it was recommended that appropriate separate payment for the brachytherapy sources be allowed so that hospitals may be reimbursed appropriately for the unique source cost per patient. Brachytherapy, also called seed implantation, involves placing radioactive sources in or near the tumor either as a permanent or temporary implant.

This comment is outside the scope of the FY 2011 IPPS/LTCH PPS proposed rule, as we did not propose any changes to the MS–DRG for brachytherapy. We refer the commenter to section II.B.2 of the proposed rule (75 FR 23864) where we discuss the timeline for submission of comments about MS–DRG classifications.

d. Excisional Debridement

We received a public comment recommending that procedure code 86.22 (Excisional debridement of wound, infection, or burn) be reclassified from an OR procedure to a non-OR procedure. The commenter stated that many excisional debridements are not performed in the operating room setting, but instead are done in wound clinics, physician offices, and in patient rooms. The commenter interpreted the classification of code 86.22 to be that of a proxy for severity of illness before MS–DRGs were implemented. With the more serious pressure ulcers, Stages 3 and 4, being classified as MCCs, according to the commenter, the need to classify code 86.22 as an OR is no longer necessary.

This comment is outside the scope of the FY 2011 IPPS/LTCH PPS proposed rule, as we did not propose any changes for excisional debridement. We refer the commenter to section II.B.2 of the proposed rule (75 FR 23864) where we discuss the timeline for submission of

comments about MS–DRG classifications.

H. Recalibration of MS–DRG Weights

As we proposed, in developing the 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 final rule include discharges occurring on October 1, 2008, through September 30, 2009, based on bills received by CMS through March 31, 2010, 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 10,898,371 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 March 31, 2010 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 final rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 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	

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48
					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	

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)
	Speech Pathology Charges	044X and 047X	Speech Pathology	C_1_C5_52	C_1_C6_52 C_1_C7_52	D4_HOS_C2_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

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)
Anesthesia	Anesthesia Charges	037X	Anesthesi-ology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44 C_1_C7_44	D4_HOS_C2_44
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45 C_1_C7_45	D4_HOS_C2_45
			Electro-encep halography	C_1_C5_54	C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41 C_1_C7_41	D4_HOS_C2_41
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42

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)
			Radioisotope	C_1_C5_43	C_1_C6_43 C_1_C7_43	D4_HOS_C2_43
Emergency Room	Emergency Room Charges	045x	Emergency	C_1_C5_61	C_1_C6_61 C_1_C7_61	D4_HOS_C2_61
Blood and Blood Products	Blood Charges	038x	Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46 C_1_C7_46	D4_HOS_C2_46
	Blood Storage / Processing	039x	Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47 C_1_C7_47	D4_HOS_C2_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 C_1_C7_58	D4_HOS_C2_58
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_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)
						C_1_C7_59	
				Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
						C_1_C7_60	
	Ambulance Charges	054X					
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
						C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X		Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_6201
						C_1_C7_6201	
				Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X				C_1_C7_6350	
				FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
						C_1_C7_6360	
				Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
						C_1_C7_64	
				Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65

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_65	
				Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
						C_1_C7_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 1.57489 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

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

Group	CCR
Routine Days	0.539
Intensive Days	0.473
Drugs	0.202
Supplies & Equipment	0.345
Therapy Services	0.403
Laboratory	0.155
Operating Room	0.272
Cardiology	0.169
Radiology	0.152
Emergency Room	0.263
Blood and Blood Products	0.415
Other Services	0.416
Labor & Delivery	0.470
Inhalation Therapy	0.200
Anesthesia	0.128

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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23922), we proposed 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 proposed 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)

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

I. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as "new technologies") under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that 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 FY 2011 MS–DRG weights in this final rule. Section 412.87(b)(2) of the regulations therefore provides that "a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the 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 final 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 IPPS/LTCH PPS final rule published in the **Federal Register** on August 27, 2009, contained the final thresholds that we used to evaluate applications for new technology add-on payments for the proposed rule for FY 2011 (74 FR 44173). However, we issued a supplemental proposed rule in the **Federal Register** on June 2, 2010 (75 FR 30756) that addressed the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we issued a **Federal Register** notice on June 2, 2010 (75 FR 31118) and further instructions that addressed the provisions of the Affordable Care Act that affected the policies and payment rates for FY 2010 under the IPPS and the LTCH PPS. In these documents, we updated Table 10 that was published in the **Federal Register** on August 27, 2009 and Table 10 in the Addendum to the FY 2011 IPPS/LTCH PPS proposed rule to reflect the changes made by the Affordable Care Act.

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 does not require a covered entity to obtain consent from patients to use or disclose protected health information for the covered entity's treatment, payment, or health care operations purposes, and expressly permits such entities to use or to disclose protected health information for these purposes and for the treatment purposes of another health care provider and the payment purposes of another covered entity or health care provider. (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** (67 FR 53208 through 53214) on August 14, 2002, for a full discussion of consent in the context of the HIPAA Privacy Rule.)

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 (CM), who is also designated as the CTI's Executive Coordinator.

The specific processes for coverage, coding, and payment are implemented by CM, 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.

Comment: A number of commenters addressed topics relating to the substantial similarity criteria, marginal cost factor for the new technology add-on payment, the potential implementation of ICD–10–CM, the use of external data in determining the cost threshold, paying new technology add-on payments for 2 to 3 years, mapping new technologies to the appropriate MS–DRG, and the use of the date that a ICD–9–CM code is assigned to a technology or the FDA approval date (whichever is later) as the start of the newness period.

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

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

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

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

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2011 prior to publication of the 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 the 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 the FY 2011 proposed rule and this final 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23926 and 23927).

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 a 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 the Institutional Review Board (IRB) granted 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/RY 2010 LTCH PPS 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. In that final rule, we noted that the Spiration® IBV® was 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.

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). Accordingly, we emphasized the need for appropriate patient selection. 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. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43823), we stated that 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we did not propose any changes to the new technology add-on payments for the Spiration® IBV®. We did not receive any public comments on whether to continue or discontinue the new technology add-on payment for the Spiration® IBV® for FY 2011. Therefore, for FY 2011, we are continuing new technology add-on payments for cases involving the Spiration® IBV® in FY 2011, with a maximum add-on payment of $3,437.50. However, we did receive one public comment on the MS–DRGs and codes used to identify which cases involving the Spiration® IBV® are eligible for the new technology add-on payment.

Comment: One commenter, the manufacturer, explained that the coding requirements described above that identify cases of the Spiration® IBV® for new technology add-on payments do not account for all cases where a hospital may be using the device to treat patients with prolonged air leaks following lobectomy, segmentectomy, and LVRS consistent with the product's HDE approval. These cases occur when the hospital inserting the Spiration® IBV® did not perform the initial lobectomy, segmentectomy, or LVRS surgery; instead, the hospital inserting the device received the beneficiary as a transfer case. The commenter explained that there are instances when a hospital performs the initial surgery and then determines that treatment of the patient with the IBV® valve is appropriate but the hospital has not been approved to perform the IBV® valve insertion procedure under the HDE regulations. Therefore, the hospital must transfer the patient to an approved facility for treatment with the IBV® valve. If it were possible to consider this situation as one case, the commenter believed that, between the two hospitals, the new technology payment criteria as specified for FY 2010 (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) would be met. However, because insertion of the IBV® valve is limited to approved facilities, the commenter believed that that the hospital receiving such a patient for treatment for prolonged air leak following lobectomy, segmentectomy, and LVRS likely reports the case under ICD–9–CM diagnosis code 512.1 (Iatrogenic pneumothorax) as the principal diagnosis in the absence of a more specific code for prolonged air leak and because the second hospital did not perform the initial lobectomy,

segmentectomy, or LVRS surgery. Such cases would be assigned to MS–DRGs 199, 200, or 201 (Pneumothorax with MCC, with CC, or with CC or MCC, respectively) based on the principal ICD–9–CM diagnosis code of 512.1 and are therefore ineligible for the new technology add-on payment based on the specifications finalized in FY 2010. In this situation, because the transferring hospital that performed the initial surgery did not insert the IBV® valve, it would also be ineligible for the new technology add-on payment. The commenter recommended that CMS allow an add-on payment in such cases by linking transfer hospitalizations cases that had an IBV® valve inserted at the receiving hospital to a previous claim in the patient's history to ensure that the patient had previously undergone a lobectomy, segmentectomy, or LVRS as reported by one of the following procedure codes: 32.22, 32.30, 32.39, 32.41 or 32.49. This would ensure that the Spiration® IBV® is being used consistent with its FDA approved indication for the treatment of prolonged air leaks following lobectomy, segmentectomy, or LVRS.

Response: We thank the commenter for the comments. We agree with the manufacturer that it is appropriate that all cases in which the Spiration® IBV® Valve is inserted consistent with its HDE approval be eligible for the approved new technology add-on payment. For this reason, we are expanding the new technology add-on payment for the Spiration® IBV® Valve to cases that map to MS–DRGs 199, 200, and 201 with an assigned principal diagnosis code of 512.1. In accordance with the FDA HDE approval, only approved hospital centers with an Internal Review Board (IRB) may implant the device. According to the manufacturer, all sites must be approved before the device will be shipped for use. The approval process includes an evaluation of the facility, training of physicians, an institutional compliance agreement, IRB process and documentation, and a purchasing agreement. The IRB ensures that the patient had a lobectomy, segmentectomy, or LVRS and had a prolonged air leak and then approves the device to be implanted in the patient. Therefore, due to the strict requirements associated with the HDE approval of this technology, even if a patient was transferred to a hospital for device implantation and the lobectomy, segmentectomy, or LVRS was not performed at that hospital (and, therefore, the surgery is not billed on the same claim as the implantation of the device), we believe our concerns regarding patient selection are addressed and that the hospital implanting the device is doing so to treat prolonged post-surgical air leaks. The manufacturer asserted that, in this transfer situation, the beneficiary's case would typically be assigned to diagnosis code 512.1, which maps to MS–DRGs 199, 200, and 201. For this reason, we are expanding the new technology add-on payment for the Spiration® IBV® Valve to cases that map to these MS–DRGs.

We performed an analysis to determine if the technology would still meet the cost criteria by adding these additional MS–DRGs to the applicant's cost analysis in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43820). The cases that map to MS–DRGs 199, 200, and 201 are small in number and, therefore, have a minimal effect on the case-weighted average standardized per case and the case-weighted threshold published in the FY 2010/RY 2010 LTCH PPS final rule. Therefore, the Spiration® IBV® would still meet the cost criteria with the inclusion of these additional MS–DRGs.

For FY 2011, in addition to making new technology add-on payments for cases of the Spiration® IBV® that map 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), we will make the new technology add-on payment for cases of the Spiration® IBV® that map to MS–DRGs 199, 200, and 201 with the presence of a diagnosis code of 512.1 in combination with procedure code 33.71 and 33.73. This determination will ensure that the hospital implanting the device receives the new technology add-on payment. We note that, in these cases, the transferring hospital performing the surgery will be subject to the transfer policy and would not receive the new technology add-on payment because it did not implant the device.

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 proposed 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.

Comment: Commenters supported our proposal to continue add-on payments for the TAH-t. The commenters believed that the TAH-t continues to represent a substantial clinical improvement for patients with biventricular heart failure in need of a heart transplant. One commenter, the manufacturer of the TAH-t, stated that the TAH-t continues to be the only biventricular replacement device that is available for patients, Medicare or otherwise, with biventricular failure. The commenter noted that the device is indicated for use as a "bridge to transplant" in cardiac transplant-eligible patients who are at risk of imminent death. The commenter stated that the device is approved by the FDA "* * * for use in-hospital, and, under a currently approved investigational device exemption ("IDE") clinical study out of hospital as well." The commenter stated that the TAH-t has been implanted in over 865 patients worldwide and that between January 1, 2009 and June 11, 2010, there were 15 TAH-t implants in the United States. Of these 15 patients, 10 were continuing on support, 4 received heart transplants, and 1 expired; the commenter stated that without the device, it is likely that all of the patients would have expired. The commenter asserted that it recently began to employ the use of a "* * * smaller, portable driver, known as the "Freedom Driver" as part of the TAH-t system." The commenter noted that the Freedom Driver allows increased patient mobility so that patients may leave the hospital while waiting for a donor heart and that the Freedom Driver further demonstrated that the TAH-t was a substantial clinical improvement. The commenter asserted that the new driver increased the operating cost of the device from $106,000 to $124,700 and requested that the new technology add-on payment be increased from $53,000 to $62,350, accordingly.

Response: We agree with the commenters that, for patients with biventricular heart failure, the TAH-t continues to represent a substantial clinical improvement. With respect to the manufacturer's request for an increase in the new technology add-on payment amount for FY 2011, we note that the version of the TAH-t that contains the Freedom Driver is not currently approved to be marketed by the FDA. Rather, the device is being studied in a clinical trial under an IDE. The IDE allows the investigational device to be used in a clinical study in order to collect safety and effectiveness data to support a Premarket Approval (PMA) application or a Premarket Notification [510(k)] submission to FDA. An approved IDE permits a device to be shipped lawfully for the purpose of conducting investigations of the device without complying with other requirements of the Federal Food, Drug, and Cosmetic Act that would apply to devices in commercial distribution. For example, sponsors are not required to have an approved PMA application or cleared Premarket Notification 510(k), register their establishment, or list the device while the device is under investigation. Sponsors of IDEs are also exempt from the Quality System (QS) Regulation except for the requirements for design control, if applicable (unless the sponsor states an intention to comply with these requirements). An IDE does not constitute FDA approval to market the device. Once the clinical trial conducted under an IDE has been completed, the device may receive FDA approval or clearance to be legally marketed. If the modified TAH-t device using the Freedom Driver does receive FDA approval, we would require that a new technology application be formally submitted for review for new technology add-on payments for the TAH-t device using the Freedom Driver at that time. Because we have not received such an

application and because the modified device is not yet approved by the FDA, we are unable to increase the new technology add-on payments for TAH–T for FY 2011. We would encourage the manufacturer to submit a new technology add-on payment application if and when it expects to receive FDA approval for the modified TAH-t with the Freedom Driver.

Therefore, as we proposed, we are continuing 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 the FY 2011 IPPS/LTCH PPS proposed rule, we are not discussing these two applications in this final rule.

A discussion of the remaining three applications is presented below. At the time the proposed rule was developed, one of the technologies had not yet received FDA approval. Since that time, that technology, the LipiScan™ IVUS, has received FDA approval.

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 laser tipped catheter designed to destroy malignant brain tumors with interstitial thermal energy causing immediate coagulation and necrosis of diseased tissue. 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 became effective on October 1, 2009.

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 (GBM) 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. In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed public comments on this issue.

With regard to the newness criterion, in the FY 2011 IPPS/LTCH PPS proposed rule, we expressed concern 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; (2) whether a product is assigned to the same or 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 head and neck. 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. In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed comments from the public regarding whether or not the AutoLITT™ is substantially similar to the Visual-ase and if it meets the newness criteria.

Comment: One commenter described the components of the AutoLITT™ that should qualify the AutoLITT™ as "new". Specifically, the commenter noted that the probe uses side-firing and has a gas-cooled tip. The commenter noted that probe drive is an MRI-compatible steering device and the software for the device provides thermal dose reporting in real time. In addition, the commenter explained that the software is designed to provide real time feedback to the surgeon and also to provide a discrete line of thermal dosage at the expanding boundary or isotherm. The commenter further explained that this isotherm is used by the surgeon to control treatment in comparison to the delineated pre-defined treatment or tumor boundary and also provides this information in a volume (that includes treatment and two axial planes) so that the surgeon can monitor and plan, in real time, the next heating cycle to complete the treatment regimen.

Response: We thank the commenter for the additional information on the AutoLITT™. After reviewing all of the information provided by the applicant and the public, we believe that the AutoLITT™ uses a different mechanism of action when compared to the Visual-ase. We agree with the applicant that the AutoLITT™ can be distinguished from the Visual-ase by its side-firing laser versus elliptical-firing. In addition, the AutoLITT™ contains a proprietary probe cooling system that removes heat from tissue not directly in the path of the laser beam, while the Visual-ase does not contain this cooling system. Therefore, we do not believe the AutoLITT™ is substantially similar to the Visual-ase. Because the AutoLITT™ was available on the market beginning with December 2009 (and is not substantially similar to its predicate device), the technology is still within the 2 to 3 year newness period.

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, the applicant asserted that clinicians will use the technology instead of performing a craniotomy for brain cancer. Additionally, the applicant asserted that clinicians will expand their use of the technology beyond GBM to 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 using the AutoLITT™ have a better tool to remove more cancer, necrotize it more precisely, and access 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 primary 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 of $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, in the FY 2011 IPPS/LTCH PPS proposed rule, we sought public 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™).

Comment: The applicant submitted supplemental information and noted that, compared to a craniotomy, surgery involving the AutoLITT™ requires an MRI and/or interventional MRI. The commenter indicated that the addition of the MRI requires additional resources, namely a MRI technician, at a minimum, and a radiologist, as needed, to review images. In total, these additions would increase the level of resources a hospital would use to treat these patients, both in terms of direct costs (for example, labor, contracted physician resources, etc.), and fixed and indirect costs (for example, MRI, use of radiology office space, etc.) The commenter further added that overall additional time for the procedure (also a cost) is currently required to conduct an AutoLITT™ case compared to the standard of care (that is, craniotomy as asserted by the applicant). The commenter reported that during the clinical trials, cases of AutoLITT™ ranged from 10 to 12 hours (including OR, MRI, and Anesthesia time as opposed to 4 to 6 hours for a craniotomy). As efficiencies are gained in the hospitals working with the technology, the applicant predicts that this time will be reduced to 7 hours within the next year or so. In addition, the commenter believed that the updated HCUP analysis, which we discuss below, supports a standardized charge of $96,947. This supplemental data correlate to 2010 pricing information that the applicant received from two institutions demonstrating an approximate charge (not standardized) of $103,000 per case.

Response: We thank the commenter for providing this information. We considered this information in our decision (indicated below) on whether the AutoLITT™ meets the cost criterion.

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. As noted above, due to section 3401(a) of the Affordable Care Act which adjusted the FY 2010 applicable percentage increase (thus requiring CMS to revise the FY 2010 standardized amounts), for this final rule, we used the revised FY 2011 thresholds as published in the FY 2010 IPPS/RY 2010 LTCH PPS notice issued in the **Federal Register** on June 2, 2010 (75 FR 31213) to determine if the AutoLITT™ met the cost criterion. Therefore, using the revised FY 2011 thresholds, the total average standardized charge per case would also exceed the cost thresholds established by CMS of $58,591 for MS–DRG 26 and $47,033 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. In the FY 2011 IPPS/LTCH PPS proposed rule, we invited public comment on whether or not the

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

AutoLITT™ meets the cost criterion for a new technology add-on payment for FY 2011.

Comment: In supplemental information provided to CMS, the applicant noted that, after further reviewing its cost analysis from the HCUP hospital data that was presented in the FY 2011 IPPS/LTCH PPS proposed rule, the applicant discovered that it inadvertently used discharges from all hospitals, including non-Medicare data, instead of only using Medicare data. Therefore, the applicant updated its analysis from the proposed rule and filtered the claims data in the HCUP database for Medicare claims with the same primary diagnosis codes listed above. Instead of the FY 2007 MedPAR database, the applicant used the most recent updated MedPAR database on the HCUP Web site, which was the FY 2008 MedPAR file. The applicant found a total of 12,816 cases with an average standardized charge of $58,061. Similar to above, 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 $96,947 ($58,061 plus $38,886). As noted above, the analysis from the HCUP database 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. Similar to above, the applicant maintains that the total average standardized charge per case significantly exceeds the revised cost thresholds established by CMS for FY 2011 in Table 10 (75 FR 31213) of $84,164 for MS–DRG 25. Additionally, the applicant maintains that the total average standardized charge per case would also exceed the cost thresholds established by CMS of $58,591 for MS–DRG 26 and $47,033 for MS–DRG 27.

Response: Even with the applicant's revised HCUP analysis, the applicant still did not establish a case-weighted average standardized charge per case by MS–DRG as required by 42 CFR 412.87(b)(3). To determine whether the applicant met the cost criterion, we performed an analysis of MedPAR data. We searched the FY 2009 MedPAR file for cases with a primary diagnosis that begins with a prefix of 191; diagnosis code 225.0; or diagnosis code 239.6. We found 1,711 cases (or 34.2 percent of all cases) in MS–DRG 25, 1,587 cases (or 31.7 percent of all cases) in MS–DRG 26, and 1,702 cases (or 34 percent of all cases) in MS–DRG 27. The average standardized charge per case was $86,678 for MS–DRG 25, $63,089 for MS–DRG 26, and $47,033 for MS–DRG 27, equating to a case-weighted average standardized charge per case of $65,685.

The average standardized charge per case does not include charges related to the AutoLITT™; therefore, it is necessary next to add the charges related to the device to the average standardized charge per case to evaluate whether the cost threshold criterion is met. As noted above, the applicant estimates $38,886 in charges related to the AutoLITT™. Adding the estimated charges related to the device to the average standardized charge per case (based on the case distribution from the FY 2009 MedPAR claims data analysis) resulted in a case-weighted average standardized charge per case of $104,571 ($65,685 plus $38,886).

Although we have established a case-weighted average standardized charge per case, the case-weighted average standardized charge per case above does not take into consideration reduced recovery time and a reduced rate of complications that would affect the total case-weighted average standardized charge per case and the average length of stay. Both would decrease the costs associated with the AutoLITT device. Therefore, we made the following calculations, taking into consideration our concerns as stated above, in order to determine if the AutoLITT™ meets the cost criteria. The average length of stay for cases we found in the FY 2009 MedPAR file was 7.4 days. This results in an average charge per day of $8,824 (the case-weighted average standardized charge of $65,685 divided by 7.4 days). However, we note that the first day of an inpatient hospitalization is typically more expensive than subsequent days in the stay. Nonetheless, absent specific charge per day data, we are equally dividing charges for purposes of evaluating the decreased costs associated with the reduced length of stay using AutoLITT™. This should provide us with a lower charge estimate than what it otherwise would be if we had actual charge data. That is, if the device meets the cost criterion based on the lower estimate, it should meet it based on the actual data, which would be higher. Based on data from the applicant's clinical trial, the average length of stay for cases with the AutoLITT™ was 3.8 days. Using the difference of 3.6 days (7.4 days minus 3.8 days) from cases in the FY 2009 MedPAR file to the applicant's clinical trial, we determined it is necessary to deduct a total of $32,154 in charges (3.6 times $8,824) from the case-weighted average standardized charge per case of $65,685, as determined above. This resulted in a reduced case-weighted average standardized charge per case of $33,531. We then added the estimated charges related to the device to the reduced average standardized charge per case and determined a revised case-weighted average standardized charge per case of $72,417 ($33,531 plus $38,886 (charges related to the AutoLITT™); all calculations above were performed using unrounded numbers).

Using the revised FY 2010 thresholds published in Table 10 (75 FR 31213), the case-weighted threshold for MS–DRGs 25, 26, and 27 was $63,408 (again, all calculations above were performed using unrounded numbers). Based on this analysis, the revised case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount. Additionally, we also conducted a sensitivity test with a majority of cases mapping to MS–DRG 25 (because the applicant maintained that most patients' conditions would be an MCC and the case would map to this MS–DRG and because patients with GBM are more likely to be more severely ill than patients with other types of tumors) and the remaining cases mapping to MS–DRGs 26 and 27. With a majority of cases mapping to MS–DRG 25, we used a higher percentage of charges from MS–DRG 25 to determine the case-weighted threshold and the case-weighted average standardized charge per case, which would make it more difficult for the case-weighted average standardized charge per case to exceed the case-weighted threshold (because the threshold for MS–DRG 25 is the highest of MS–DRGs 25, 26, and 27). The sensitivity test demonstrated that even with a majority of cases mapping to MS–DRG 25, the case-weighted standardized charge per case would exceed the case-weighted threshold.

After reviewing all of the data summarized above, we believe the applicant has provided a sufficient explanation for the additional charges associated with the AutoLITT™, even with a reduced recovery time and a reduced rate of complications. Additionally, our analysis of the FY 2009 MedPAR data demonstrates that the average standardized charge per case (for cases eligible for the AutoLITT™) does exceed the case-weighted cost threshold (even with a majority of cases mapping to a MS–DRG). Furthermore, the applicant did provide charge data from two centers verifying the expected high charges associated with the cases of the AutoLITT™. Therefore, we believe that the AutoLITT™ meets the cost criterion.

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 GBM 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 to or inability of these therapies to treat the brain tumor (due to tumor location, type, or size, among other reasons). 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).

In the FY 2011 IPPS/LTCH PPS proposed rule, we stated that, 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. In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed additional clinical data to demonstrate whether the AutoLITT™ meets the substantial clinical improvement criterion and invited public comment on whether or not the AutoLITT™ meets the substantial clinical improvement criterion.

Comment: A number of commenters who are physicians agreed with the applicant that the AutoLITT™ meets the substantial clinical improvement criterion. Two commenters (that conducted the clinical trial) described their experience with the AutoLITT™ in the clinical trial for use in patients with recurrent GBM who were demonstrated to be refractory to other treatment options. (We note that this clinical trial is also discussed below in a separate comment from the manufacturer). The commenters treated 10 patients with the AutoLITT™ and noted the following: (1) A short recovery time that allowed patient discharges within 2 to 3 days, compared to 3 to 5 days following a craniotomy; (2) patients were able to ambulate more quickly, typically within 3 to 4 hours, compared to craniotomy which often takes 6 or more hours of recovery time prior to becoming ambulatory (The commenters noted that this is important in the prevention of venous thrombosis, commonly seen in patients with GBM.); and (3) adverse events have been minimal and do not exceed those published for first or second craniotomies for glioblastomas.[5] The commenters noted that, over time, adverse events are likely to decrease as clinical experience is gained with the AutoLITT™ and will likely be less than those experienced with craniotomy, due to the less invasive nature of the AutoLITT™.

Other commenters who have reviewed the most recent clinical data on the AutoLITT™ expressed their support for the clinical benefits of the AutoLITT™. One commenter stated it foresees using the AutoLITT™ on deep seated primary tumors for which total resection would risk a major insult to the brain and/or its functional structures. The commenter further stated that use of the AutoLITT™ would minimize hospitalization, and possibly reduce complications, such as thromboembolic events, seen with other therapies. Another commenter added that there are many patients with metastases to the brain and more than 10 percent of patients who receive Gamma Knife treatment for such brain metastases have recurrence of the metastasis at or near the original site. The commenter stated it would consider the AutoLITT™ as an alternative to Gamma Knife treatment in these cases because Gamma Knife treatment dramatically increases the risk of symptomatic radiation necrosis. All of these commenters stated that the AutoLITT™ offers additional quality of life in patients with GBM due to its reduced recovery time and its use as a less invasive alternative treatment to other available treatment options.

Response: We appreciate these comments. Some commenters described their positive experiences using the AutoLITT™ which reduced recovery time for the patient. Other commenters noted that they would use the AutoLITT™ as an alternative to other available treatments because it is less invasive and provides an improved quality of life for the patient outside the hospital. We considered the comments above in our determination (indicated below) on whether the AutoLITT™ represents a substantial clinical improvement.

Comment: The manufacturer submitted two public comments that addressed the substantial clinical improvement criterion. The first comment reiterated that options available to treat patients with brain tumors are limited in general, and these limitations are magnified by the fact that many patients are refractory to currently available options such as surgical resection via craniotomy and radiotherapy. The comment further stated that the literature on AutoLITT™ and LITT has demonstrated that the AutoLITT™ offers another clinically viable option to brain cancer patients, especially after other options have failed.

Below we highlight some of the results of the clinical studies cited by the commenter:

- Time to progression of disease and survival were longer for brachytherapy plus LITT compared to brachytherapy;[6]
- Survival time using LITT/MRI therapy was substantially longer than the natural history of the disease and longer than using chemotherapy alone. After a short surgeon learning curve, the

[5] Chang *et al.,* J. Neurosurg., vol. 98, pp. 1175–1181, 2003.

[6] Sneed, PK *et al.* (1998). Survival benefit of hyperthermia in a prospective randomized trial of brachytherapy boost + hyperthermia for glioblastoma multiforme. *International J. Radiation Oncology Biol. Phys.;* 1998: 287–295.

median survival time increase by up to a factor of 4× (p = 0.0267);[7]

• Use of MRI guidance in brain surgery alone has demonstrated a statistically significant reduction in major complications versus surgery without MRI guidance (p = 0.019);[8] and

• The combination of LITT and MRI guidance for treating metastatic intracranial tumors has been evaluated for safety and feasibility [9] in a study of four patients that were refractory to other treatments. The patients demonstrated on follow up that in all cases the procedure was well tolerated without secondary effect and patients were discharged within 14 hours after the procedure. Upon a 90-day follow up, tumor volume demonstrated a gradual and steady decrease, with no recurrence within the thermal ablation zones.

The commenter concluded that it carefully reviewed the available literature on LITT and believes that the AutoLITT™ has demonstrated the following positive clinical benefits for patients: a robust and clinical validated integrated platform of clinically useful technologies (LITT, MRI guidance, real time MR monitoring of thermal energy applications) that works within the existing clinical frameworks available at major medical centers; effective abilation of targeted tumor tissue; short length of stay; ability to ambulate early; and minimally lasting or late developing side effects. As a result, the commenter believes that the AutoLITT™ represents a new, clinically viable option for brain cancer patients and meets the substantial clinical improvement criteria.

The other comment from the manufacturer discussed the applicant's clinical trial. Some of these data were discussed above in the comments we received from physicians in support of the AutoLITT™. The manufacturer provided more detail about the design of the clinical study. The manufacturer stated that it conducted a clinical trial of 10 patients with tumors in locations that either made access to the tumor without risk of complications difficult or made total gross resection of the entire mass impossible or impractical without significant risk. All patients treated in the study had first or second GBM tumors with poor prognosis. The Karnofsky Performance Scale used to measure functional and mental status was assessed pre- and post-treatment and remained the same or improved during the post treatment interval. Finally, as also mentioned in the comments from the physicians in support of the AutoLITT™, all patients in the clinical study were discharged within 2 to 7 days with a mean of 3.8 days, which compares favorably to a 12-day average length of stay for cases that map to MS–DRG 25.

Response: We thank the applicant and all of the commenters for providing additional clinical data to demonstrate that the AutoLITT™ meets the substantial clinical improvement criteria. With respect to substantial clinical improvement, we considered all of the case-specific clinical information presented by the applicant and the public to determine whether there is evidence to support a conclusion that use of the AutoLITT™ represents a substantial clinical improvement. Specifically, we focused our review on the peer-reviewed medical literature and the results of the clinical studies. We remain concerned that no prospective comparative data exist to help understand the benefit of the technology compared to other modalities.

However, we agree that the AutoLITT™ can improve clinical outcomes by providing an alternative treatment for brain tumors that potentially has a lower risk of adverse events and is less invasive compared to craniotomy. Also, the comments we received from the physicians and the manufacturer noted that the AutoLITT™ provides a new treatment option in cases where no existing treatment was available due to the risk of complications or total gross resection of the entire mass made impossible or impractical without significant risk. Lastly, we received positive comments from physicians who indicated that the AutoLITT™ is a less invasive treatment than other alternative treatments such as craniotomy and produced positive clinical outcomes by reducing average length of stay, quicker ambulation, and a reduction of other adverse events that occur in cases of first or second craniotomies for glioblastomas. Although we continue to believe that limited, anecdotal reports from physicians using a new technology are insufficient to demonstrate substantial clinical improvement over existing technologies, such information, when considered together with peer-reviewed medical literature and results of clinical studies, can help to inform our decision. Therefore, after reviewing the totality of the evidence, we have determined that the AutoLITT™ meets the substantial clinical improvement criterion.

Accordingly, after consideration of the clinical evidence received, we are approving the AutoLITT™ for new technology add-on payments in FY 2011. Consistent with the applicant's clinical trial, the add-on payment is intended only for use of the device in cases of Glioblastoma Multiforme. Therefore, we intend to limit the new technology add-on payment to cases involving the AutoLITT™ in MS–DRGs 25, 26, and 27. Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS–DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with a primary diagnosis codes that begins with a prefix of 191. We note that using the procedure and diagnosis codes above and restricting the add-on payment to cases that map to MS–DRGs 25, 26, and 27 is consistent with information provided by the applicant, which demonstrated that cases of the AutoLITT™ would only map to MS–DRGs 25, 26, and 27. Procedure code 17.62 does not map to MS–DRGs 25, 26, or 27 under the GROUPER software and, therefore, is ineligible for new technology add-on payment.

The average cost of the AutoLITT™ is reported as $10,600 per case. Under § 412.88(a)(2) of the 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, the maximum add-on payment for a case involving the AutoLITT™ is $5,300.

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.

[7] Schwarzmaier, HJ *et al.* (2006). MR guided laser-induced interstitial thermotherapy of recurrent glioblastoma multiforme: Preliminary results in 16 patients. *Eur. J. Radiology; 59: 208–215.*

[8] Paleologos, TS *et al.* (2000). Clinical Utility and Cost-Effectiveness of Interactive Image Guided Craniotomy: Clinical Comparison between Conventional and Image Guided Meningioma Surgery. *Neurosurgery; 47:* 40–48.

[9] Carpentier, A. *et al.* (2008). Real-Time Magnetic Resonance Guided Laser Thermal Therapy for Focal Metastatic Brain Tumors. *Neurosurgery; 63:* ONS21–ONS29.

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.
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. In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed public comment on whether Lipiscan™ meets the newness criterion.

Comment: One commenter, the manufacturer, stated that the LipiScan™ met the newness criterion based on its FDA approval date.

Response: We agree that the LipiScan™ is new as of the date of its supplemental FDA approval, April 25, 2008, because the manufacturer provided information to us to show that the device was not marketed until after the supplemental FDA approval. Accordingly, 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 IPPS/RY 2010 LTCH PPS 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-Veterans Administration

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). In the FY 2011 IPPS/LTCH PPS proposed rule, we used the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) to determine if the Lipiscan™ met the cost criterion. For this final rule, due to the provisions of section 3401(a) of the Affordable Care Act which adjusted the FY 2010 applicable percentage increase (thus requiring CMS to revise the FY 2010 standardized amounts), we used the revised FY 2011 thresholds as published in the FY 2010 IPPS/RY 2010 LTCH PPS notice issued in the **Federal Register** on June 2, 2010 (75 FR 31213) to determine if the Lipiscan™ meet the cost criterion. Based on the revised FY 2011 Table 10 thresholds, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,466 (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 to 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 2011 AOR file (in the proposed rule, we used the FY 2010 AOR file; however, for this final rule, we used the most recent data available, which is the FY 2011 AOR file), for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,663, 141,780, 14,281, 46,037, 7,591, and 36,059 cases, respectively. Using this case distribution and the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 (that is, $73,006, $48,275, $67,954, $44,336, $65,238, and $44,504, respectively, as stated above), we calculated that the case-weighted average standardized charge per case is $51,353. 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 2011 AOR final rule file) results in a total case-weighted average standardized charge per case of $58,850 ($51,353 plus $7,497). Using the revised FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31213) and the actual case distribution from the FY 2011 AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,940 (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. In the FY 2011 IPPS/LTCH PPS proposed rule, we invited public comment on whether or not Lipiscan™ meets the cost criterion. We did not receive any public comments on whether or not Lipiscan™ meets the cost criterion. Therefore, for FY 2011, we have determined that Lipiscan™ meets the cost criterion.

With regard to substantial clinical improvement, we 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, we 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 the 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 September 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.

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

The applicant also submitted commentary from a group of interventional cardiologists 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed public comment regarding whether or not the LipiScan™ technology represents a substantial clinical improvement for the Medicare population.

Comment: One commenter, a trade association for interventional cardiologists, stated that it appreciated CMS' clarification in the proposed rule that "a new diagnostic technology can meet the substantial clinical improvement criterion not just by demonstrating improvement in clinical outcomes, but also on the basis of evidence showing changes in the management of the patient." This commenter stated that, in light of the "clarification," it supported the approval of the LipiScan™ for new technology add-on payments.

Response: This comment mischaracterizes CMS' position regarding the required showing for a diagnostic technology to meet the

substantial clinical improvement criterion. CMS has not stated that a new diagnostic technology can meet the substantial clinical improvement criterion not just by demonstrating improvement in clinical outcomes, but also on the basis of evidence showing changes in the management of the patient. As we stated in the September 7, 2001 **Federal Register**, we follow certain guidelines to determine whether a technology represents a substantial clinical improvement. For a diagnostic technology, we make this determination by judging whether the technology "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. There must also be evidence that use of the device to make a diagnosis affects the management of the patient." (66 FR 46914)

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43818), we further discussed what evidence an applicant must show in order to meet the substantial clinical improvement criterion for diagnostic technologies. We continue to believe that it would not be appropriate to provide additional payments for new diagnostic tools that fail to significantly change the management of patients, thereby improving clinical outcomes.

Comment: Commenters supported deeming the Lipiscan™ to be a substantial clinical improvement over currently available technologies. The manufacturer stated that the use of LipiScan™ increased from 100 cases in late 2008 to 900 cases by June 2010, and that the number of hospitals using the technology has increased from 16 to 22. Additionally, over 350 patients are enrolled in the manufacturer's registry of cases involving LipiScan™, COLOR. The manufacturer asserted that the data now available clearly identify three specific clinical implications of the detection of lipid core plaque: (1) To predict and minimize the occurrence of peri-stenting MI; (2) to identify the length of artery to be stented; and (3) to assist in selection of the intensity of pharmacologic therapy following stenting.

The manufacturer submitted the chemogram images of 44 stabilized patients who were stented and in whom enzymes are available to determine if an MI occurred during stenting. Some of the 44 patients had the presence of large lipid core plaque; others did not. Eight of these patients were found to have experienced an MI during stenting (as identified by a cardiac enzyme elevation of greater than or equal to 3x ULN).

With respect to LipiScan™'s ability to predict and minimize the occurrence of peri-stenting MI, the manufacturer referenced a doctor who had used filters or embolic protection during stenting. That doctor's summary is presented is the next paragraph. With respect to identifying the length of artery to be stented, the manufacturer stated that "a case has now been observed in which acute stent thrombosis occurred when a stent * * * ended in a lipid core plaque, as documented in vivo by LipiScan™." The manufacturer asserted that the evidence linking stent thrombosis to termination of a stent in a lipid core plaque has led physicians to use the image provided by LipiScan™ as a factor determining the length of artery to be stented. With respect to LipiScan™ assisting in the selection of the intensity of medical therapy post-stenting, the manufacturer maintained that "the development of [LipiScan™] now makes it possible to perform in vivo assessment of the relationship between the presence of lipid core plaque and coronary event." The manufacturer submitted before and after chemograms in which the baseline chemogram did not show lipid core plaque. In subsequent days, ranging from 42 to 316 days, the manufacturer added, the patients still had no lipid rich plaque. The manufacturer asserted that these cases "correctly predicted the continued patency of the artery and the absence of a coronary event related to that artery." The manufacturer showed a baseline and 325 day follow-up of a patient who did have lipid rich plaque at baseline and had a re-stenosis of the lipid rich area 325 later.

The commenters who supported this technology generally made anecdotal assertions in which the information provided by LipiScan™ was useful to them in managing their patients. One commenter, a physician, stated that he had used the identification of lipid core plaque (as identified by LipiScan™) in an attempt to protect patient from the high risk of peri-stenting MI by "placing a distal protection filter beyond the lipid core stenosis to be dilated." This commenter asserted that such filters are used in dilation of saphenous vein grafts which have rates of periprocedural MI that can be reduced by approximately 40 percent if embolic protection is used. The commenter used protection devices before stenting in the native coronary arteries seven patients with large lipid core plaque as assessed by LipiScan™. A filter was used in six patients and a proximal embolic protection was used in one patient. The commenter stated that he believed that the rate of infarction was lower in these seven patients than it would have been had embolic protection devices not been utilized, and that the two infarctions that did occur were smaller than they would have been if the full load of debris mobilized by balloon inflation—included the debris collected in the first basket—would have lodged in the distal vessels.

Another physician stated that there "have been anecdotal cases by multiple operators of the catastrophic no reflow phenomenon in patients who underwent angioplasty of a lipid rich stenosis [LipiScan™] imaging may be able to identify these patients and hopefully prevent this catastrophic complication" The same commenter stated that the diagnostic information provided by the LipiScan™ chemogram "can be combined with well-established treatments * * * as a means to reduce stenting complications and peri-stenting MI." Some commenters believed they could reduce the incidence of heart attacks that occur during stenting by using a filter to remove the lipid-rich plaque.

Another commenter stated that, although he does not perform interventional cardiology procedures, he was interested in how the information provided by LipiScan™ could contribute to the prevention of initial and secondary coronary events. He described an asymptomatic man who participated in a clinical research study designed to evaluate the noninvasive identification of patients at increased risk of coronary events. He stated that the patient had a "noninvasive CTA" and that positive results led to a cardiac catherization in which LipiScan™ was used. Based on the chemogram, which showed extensive lipid core plaque, the clinicians decided to treat this patient with intensive lipid altering therapy. The commenter did not describe any followup for that patient.

Another commenter, a physician, stated that he performed approximately 70 procedures with the LipiScan™ since 2008. The commenter asserted that in roughly 75 percent of these procedures, the "lesion characterization information provided by the Lipiscan image affected [his] diagnosis of the patient's condition." In approximately 50 percent of the procedures, the commenter stated that the imaging information affected his treatment of the patient's condition. The commenter further stated that the most significant changes involved his decisions about which segments of the artery required treatment, the length of stent to employ, and the type of stent he chose to

employ. The commenter provided information on three specific cases in which he used LipiScan™. In two of the cases, he indicated that he was better able to choose the length of stent and in one case, the use of LipiScan™ helped guide the selection of the type of stent to be used; although the patient did suffer a heart attack, the stenting was able to proceed.

Response: In the case of LipiScan™, we note that existing technologies may not be able to adequately identify lipid-rich plaques. However, methods exist currently for diagnosing CAD, including intravascular ultrasound (IVUS) and optical coherence tomography (OCT). We also reiterate that such diagnostic capability must also be linked to "evidence that use of the device to make a diagnosis affects the management of the patient." In this case, the evidence currently available to CMS consists of anecdotal claims made by the applicant and one other commenter that the identification of such plaques affects the management of the patient. A review of the literature yielded no additional evidence base to support the applicant's claim regarding the effect of this technology on patient management. Furthermore, as we stated last year, we continue to believe that the prognostic implications of detecting lipid-rich plaque are not yet sufficiently well understood and documented in the peer-reviewed evidence base to conclude that its identification will lead to widespread and evidence-based changes in the management of CAD.

We believe that a diagnostic technology must necessarily have evidence-based, significant, and positive effects on the management of patients, thereby resulting in improved clinical outcomes generally accepted by clinicians, in order to meet the threshold of representing an advance that substantially improves, relative to technologies previously available, the diagnosis of Medicare beneficiaries.

In response to the comments that the LipiScan, combined with a filter could reduce the incidence of peri-stenting MI, we note that use of such a filter in the coronary vasculature is not currently approved by the FDA and therefore is "off-label" to the extent that it is already being employed by physicians. The most recent article submitted to us by the applicant (dated 2010), an "Imaging Vignette" which does not appear to have been published yet, concludes: "Additional studies are needed to quantitate the ability of NIRS to predict the occurrence of peri-stenting infarction and to test, in a randomized trial, the strategy of NIRS guided use of a distal protection device" (Goldstein, et al). We agree with the commenters that use of such filter may ultimately reduce the incidence of peri-stenting MI to the extent that it aides the physician in placing the stent such that it does not cause the lipid core plaque to rupture. However, absent FDA approval for this indication, we do not believe it is appropriate to consider this use as part of our evaluation of substantial clinical improvement for the LipiScan™. We also agree with the vignette's conclusion that additional clinical studies are needed to evaluate this claim.

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

In addition, we are concerned that there continues to be relatively few cases in which Lipiscan™ has been used relative to the patient population in which it could potentially be used. As we have previously explained, we do not consider merely anecdotal claims that a device affects the management of the patient as sufficient evidence to demonstrate that a new diagnostic device affects the management of the patient, particularly where the device could be used for a relatively large patient population. Specifically, the applicant claims that the device could potentially be used in every patient who undergoes coronary angiography. To date, the device is only in use in 22 hospitals total and, as noted above, there has been no data published, or even reported, from the hospitals where the device has been used, to indicate that management of patients has changed and that patients who received LipiScan™ had better clinical outcomes than those who did not.

We believe that the lack of comparative data from hospitals showing statistically valid improved outcomes for the patients who received LipiScan™ compared to those who did not receive the technology further supports our previously stated view that the prognostic implications of detecting lipid-rich plaque are still not well enough understood and therefore the detection of such plaque cannot be reasonably assumed to automatically lead to evidence-based, significant, and positive in the management of patients with CAD generally accepted by clinicians, much less lead to improved clinical outcomes. We agree with the commenters and applicant that the identification of lipid-rich plaques by LipiScan™ may *potentially* hold promise and ultimately lead to changes in the management of CAD and that Lipiscan™ has the potential to provide additional benefits in clinical outcomes of patients with CAD. However, we do not believe the evidence and information available at this time allows us to determine that it meets the substantial clinical improvement criterion.

Accordingly, we are not approving Lipiscan™ for new technology add-on payments for FY 2011.

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.

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).

With respect to the newness criterion, we noted in the proposed rule that this device was not currently approved by the FDA, but the manufacturer anticipated that FDA approval will be granted in the second quarter of 2010. We also noted that IVUS has existed for over 20 years. Therefore, IVUS, on its own, would not meet the newness criterion. The applicant asserted 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 asserted that the single-use catheter for the combined technologies is only supplied by InfraReDx (the manufacturer of LipiScan™). However, we noted 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed 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 welcomed 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).

Comment: One comment, the manufacturer, stated that it agreed with the proposed rule statement of "it appears that LipiScan™ IVUS meet the newness criterion." Additionally, the commenter stated that should the LipiScan™ IVUS receive FDA approval, it should be considered new because LipiScan™ IVUS provides the individual benefits of both LipiScan and IVUS, "plus accurate co-registration, synergistic benefits, and enhanced safety and ease of use we believe that the LipiScan™ IVUS multimodality imaging catheter should be considered new if and when it receives clearance by the FDA and is marketed." The commenter did not specifically address the three criteria considered under substantial similarity.

Response: We note that the LipiScan™ IVUS received a 510(k) approval from the FDA on June 30, 2010, prior to the July 1 deadline that applicants for new technology must meet in order to be evaluated under the newness criterion. The FDA approval letter did not provide information that would distinguish the LipiScan™ IVUS from its predicate devices. In addition, the manufacturer did not provide enough information for us to distinguish the LipiScan™ IVUS from the LipiScan™, which is what we specifically questioned in the proposed rule. (Indeed, we note that the uses for both devices appear to be markedly similar.) Also, we did not state in the proposed rule that the technology meets the newness criterion, as the commenter suggested. We note that under FDA's 510(k) approval process, there must be at least one predicate device that is "substantially equivalent." However, as we have stated previously, we do not believe that a determination of substantial equivalence by FDA under the 510(k) approval process necessarily means that a technology is substantially similar to its predicate device(s) for purposes of the new technology add-on payment.

Moreover, none of the public commenters specifically addressed whether the LipiScan™ IVUS was substantially similar to the LipiScan™. Specifically, none of the public commenters, including the manufacturer, addressed: (1) Whether the products use the same or similar mechanism of action to achieve a therapeutic action; (2) whether the products are 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. As a result, we do not believe that we have sufficient information to make an affirmative decision regarding whether the LipiScan™ IVUS is substantially similar to the LipiScan™. Accordingly, we are not making a determination regarding whether the LipiScan™ IVUS is substantially similar to its predicate device or the LipiScan™ in this final rule. However, we note that whether or not LipiScan™ IVUS was substantially similar to LipiScan™, the LipiScan™ IVUS is still within its newness period for FY 2011 (because the LipiScan™ was new as of April 2008 and is still within its "newness" window for FY 2011). Accordingly, we believe that LipiScan™ IVUS meets the newness criterion for FY 2011, but we do not have sufficient information regarding whether or not the start of the newness period began in April 2008 or June 2010. Therefore, we are not making a determination in this rulemaking regarding the start of the newness period.

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2010 IPPS/RY 2010 LTCH PPS final rule 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 laboratories, the applicant determined the mean CCR was 0.188 with a markup of 532 percent, yielding a charge of $15,960 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 derived from a sample of hospitals.) 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). In the FY 2011 IPPS/LTCH PPS proposed rule, we used the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) to determine if the Lipiscan™ IVUS meets the cost criterion. For this final rule, due to the provisions of section 3401(a) of the Affordable Care Act which adjusted the FY 2010 applicable percentage increase (thus requiring CMS to revise the FY 2010 standardized amounts), we used the revised FY 2011 thresholds as published in the FY 2010 IPPS/RY 2010 LTCH PPS notice that appeared in the **Federal Register** on June 2, 2010 (75 FR 31213) to determine if the Lipiscan™ IVUS meets the cost criterion. Based on the revised FY 2011 Table 10 thresholds, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,466 (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 to the applicant's assertion that the probability of use of Lipiscan™ IVUS is the same in each of those six MS–DRGs. Using data from the FY 2011 AOR file (in the proposed rule, we used the FY 2010 AOR file; however, for this final rule, we used the most recent data available, which are contained in the FY 2011 AOR file), for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,663, 141,780, 14,281, 46,037, 7,591, and 36,059 cases respectively. Using this case distribution and the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 (that is, $73,006, $48,275, $67,954, $44,336, $65,238, and $44,504, respectively, as stated above), the case-weighted average standardized charge per case is $46,949. 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 $62,909 ($46,949 plus $15,960). Using the revised FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31215) and the actual case distribution from the AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,940 (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 revised FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31215), the case-weighted threshold for MS DRGs 246, 247, 248, 249, 250, and 251 is $52,671 (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. In the FY 2011 IPPS/LTCH PPS proposed rule, we invited public comment on whether or not Lipiscan™ IVUS meets the cost criterion. We did not receive any public comments in this regard. Accordingly, we find that for FY 2011 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™ IVUS 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 percent of cases due to three 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 the 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. We note that the applicant did make this assertion with regard to Lipiscan™ and not Lipiscan™ IVUS.

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 LipiScan™ 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, although the applicant did maintain that the use of one catheter to co-register of the near infrared (NIR) mirrors and the ultrasound transducer can enhance the accuracy of output and can have safety benefits. Indeed, we note that most of the studies that were presented in an effort to demonstrate 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we welcomed 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 device for LipiScan™ IVUS.

Comment: Many of the commenters who supported the LipiScan™ application also stated that, should the LipiScan™ IVUS receive FDA approval, they believed that it would offer similar benefits to the LipiScan™. For this reason, these commenters were supportive of LipiScan™ IVUS being approved for the new technology add-on payments. The manufacturer commented that the LipiScan™ IVUS "has been constructed and used successfully in seven patients in Rotterdam, Netherlands" and that it was featured in a live case presentation at "EuroPCR," "the leading meeting of interventional cardiologists in Europe."

The manufacturer also stated that LipiScan™ IVUS provides the benefits of LipiScan™ and IVUS plus several synergistic benefits. Specifically, the manufacturer noted the co-registration of the near infrared (NIR) mirrors and the ultrasound transducer enhances the accuracy of the output. The IVUS shows the location of the catheter in the artery while the NIR enhances the interpretation of the grayscale IVUS image. The manufacturer stated that "once NIR has clearly shown that a lipid core is present, it is possible to re-examine the IVUS image for features such as an estimate of cap thickness." The manufacturer also stated that there are safety benefits associated with using one catheter to obtain both the NIR image and the IVUS image and noted that with each insertion of a catheter comes the risk of an adverse event such as a stroke or myocardial infarction. Additionally, the manufacturer stated that combining both technologies into one catheter reduces procedure time, radiation exposure and contrast utilization. The manufacturer stated that a peer-reviewed manuscript has been published by Garg, *et al.*

Response: According to the applicant, there have only been seven cases in which the LipiScan™ IVUS has been used, none of them in the United States (and, ostensibly, none on a Medicare beneficiary). Despite the applicant's claims that the combined LipiScan™ IVUS technology enhances the benefits of either LipiScan™ or IVUS alone as well as LipiScan™ and IVUS used simultaneously, but with two separate catheters, we do not believe that there is enough clinical evidence relating to this technology to support this claim or to demonstrate that the technology is a substantial clinical improvement over other existing diagnostic technologies. That is, the evidence available at this time does not support that the LipiScan™ IVUS affects the medical management of the patient which, in turn, leads to improved clinical outcomes. We also note that we did not believe that there was enough clinical evidence available at this time to substantiate the claims that LipiScan™ by itself is a substantial clinical improvement. To the extent that the same information was submitted to support the applicant's LipiScan™ IVUS application, we also find, for the reasons discussed above, that the evidence is insufficient to demonstrate that the LipiScan™ IVUS represents a substantial clinical improvement over existing technologies. The manuscript that the applicant referred to simply describes what the technology does and how it is used; it does not provide any details as to how the technology affects the medical management of patients nor does it provide evidence that use of the LipiScan™ IVUS ultimately leads to improved clinical outcomes for patients. Although we recognize that the combination of these two existing technologies may ultimately lead to better clinical outcomes for patients undergoing coronary stenting, no data is available at this time to support that notion.

Accordingly, we are not approving the LipiScan™ IVUS device for new technology add-on payments for FY 2011.

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

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the FY 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 adjustment for FY 2011 is discussed in section II.B. of the Addendum to this final rule.

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

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are applying beginning October 1, 2010 (the 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 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 and 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 did not propose any additional changes regarding reforming the wage index for the FY 2011 IPPS. We welcomed comments regarding the second part of Acumen's final report.

Comment: Several commenters addressed the data source for constructing the wage index. One commenter supported the use of BLS data and suggested that a simplified, standard dataset will eliminate unnecessary reclassifications and inconsistencies among Medicare contractors and create a more valid wage index calculation. Other commenters reiterated the concerns about the shortcomings of the BLS data that they expressed in public comments summarized in the FY 2009 IPPS final rule (73 FR 48564). One commenter suggested that CMS use data that reflect the price of labor rather than the cost of labor in constructing the wage index. The commenter also suggested that the wage index include data from SNFs and other postacute care settings because the wage index is also applied in those Medicare provider payment systems.

Regarding the methodology for constructing the wage index, several commenters shared Acumen's concern that MedPAC's blending and smoothing methodology may not be well suited for the Medicare wage index because it may mask actual geographic variations in wage levels. However, the commenters supported MedPAC's suggestion of varying wage indices by more refined areas, such as counties. Several commenters also expressed interest in Acumen's suggestion for further exploration of labor market area definitions based on hospital specific characteristics, such as the commuting times from hospitals to population centers.

One national hospital association recommended that CMS consider the following guiding principles as it evaluates options for improving the wage index system:

"Any new system should—
- Be fair and accurately reflect the labor marketplace for hospitals, e.g., consider only hospital wage and benefit costs rather than broader labor market costs;
- Provide predictable payments;
- Be stable;
- Be transparent so that the data may be examined and verified;
- Minimize the administrative burden on hospitals;
- Utilize the most current information possible;
- Define boundaries that capture meaningful relationships between labor markets, to reduce the need for exceptions and reclassifications;
- Due to the imperfection of any current labor market definition that we are aware of, provide an exception process for hospitals with labor costs atypical for areas to which they have been assigned;
- Use consistent definitions, methodologies, rules, and interpretations

across the nation for the acquisition and application of data;

- Include a transition from the old to the new system that is not disruptive; it should include a phased-in transition period if necessary to protect hospitals from abrupt reductions in payment levels; and
- Not let perfection be the enemy of the better."

Commenters generally urged CMS to move forward cautiously and ensure a thorough process for evaluating changes to the existing wage index.

Response: As discussed in section III.B.4. of the preamble in this final rule, section 3137(b) of the Affordable Care Act requires the Secretary of Health and Human Services to submit to Congress, not later than December 31, 2011, a report that includes a plan to reform the Medicare wage index applied under the Medicare IPPS. We will consider the MedPAC's and Acumen's reports and findings, along with all of the public comments and suggestions we have received, as we evaluate ways for improving the wage index.

2. FY 2009 Policy Changes in Response to Requirements Under Section 106(b) of the MIEA–TRHCA and Subsequent Changes Under Sections 3137(c) and 3141 of the Affordable Care Act

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 policy changes to the wage index relating to geographic reclassification average hourly wage comparison criteria and rural and imputed floor budget neutrality. (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/RY 2010 LTCH PPS final rule (74 FR 43825), we reiterated these policy changes, especially as they related to the FY 2010 IPPS. However, provisions of the Affordable Care Act recently changed the reclassification average hourly wage comparison criteria and rural and imputed floor budget neutrality policies that we adopted in FY 2009.

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 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 policies.) 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 were 88 percent for urban and group reclassifications and 86 percent for rural hospitals. Sections 412.230, 412.232, and 412.234 of the regulations were revised accordingly. These policies were adopted in the FY 2009 IPPS final rule and were reflected in the wage index in the Addendum to the FY 2011 IPPS proposed rule, which appeared in the **Federal Register** on May 4, 2010.

However, as we discussed in the supplemental proposed rule to the FY 2011 IPPS/LTCH PPS proposed rule issued in the **Federal Register** on June 2, 2010 (75 FR 30919), the provisions of section 3137(c) of the Affordable Care Act revised the average hourly wage standards. Specifically, section 3137(c) restored the average hourly wage standards that were in place for FY 2008 (that is, 84 percent for urban hospitals, 85 percent for group reclassifications, and 82 percent for rural hospitals) for applications for reclassification for FY 2011 and for each subsequent fiscal year until the first fiscal year beginning on or after the date that is one year after the Secretary of Health and Human Services submits a report to Congress on a plan for reforming the wage index under section 3137(b) of the Affordable Care Act. Section 3137(c) of the Affordable Care Act also requires the revised average hourly wage standards to be applied in a budget neutral manner. We note that section 3137(c) of the Affordable Care Act does not provide for the revised average hourly wage standards to be applied retroactively, nor does it change the statutory deadline for applications for reclassification for FY 2011. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (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). For reclassifications for the FY 2011 wage index, the deadline for applications was September 1, 2009 (74 FR 43838).

As we discussed in the June 2, 2010 FY 2011 supplemental proposed rule (75 FR 30919 and 30920), in our proposed implementation of section 3137(c) of the Affordable Care Act, we requested the assistance of the MGCRB in determining, for applications received by September 1, 2009, whether additional hospitals would qualify for reclassification for FY 2011 based on the revised average hourly wage standards of 84 percent for urban hospitals, 85 percent for group reclassifications, and 82 percent for rural hospitals restored by section 3137(c). We determined that 18 additional hospitals would qualify for reclassification for FY 2011. In addition, 5 hospitals, for which the MGCRB granted reclassifications to their secondary requested areas for FY 2011, would qualify for reclassifications instead to their primary requested areas because they now meet the average hourly wage criteria to reclassify to those areas. Therefore, in accordance with § 412.278 of the regulations, in which paragraph (c) provides the Administrator discretionary authority to review any final decision of the MGCRB, we submitted a letter to the Administrator requesting that she review and amend the MGCRB's decision and grant the 23 hospitals their requested reclassifications (or primary reclassifications) for FY 2011. The proposed wage index in the Addendum to the June 2, 2010 supplemental proposed rule (75 FR 30984) reflected these changes in hospital reclassifications, although the Administrator had not issued all of her decisions by the issuance date of the supplemental proposed rule. We stated that any changes to the FY 2011 wage index, as a result of the Administrator's actual decision issued under § 412.278(c), or an amendment of the Administrator's decision issued under § 412.278(g), would be reflected in the FY 2011 IPPS final rule. As a result of her review, the Administrator amended the MGCRB's decision for 22 of the 23 hospitals for the FY 2011 wage index. One hospital had decided to withdraw its approved reclassification for FYs 2011 through 2013 and, instead, "fall back" to its prior reclassification for FYs 2010 through 2012. (We refer readers to 42 CFR 412.273 and the discussion on withdrawals, terminations, and "fall back" reclassifications in section III.I.3.a. of the preamble in this final rule.)

In the June 2, 2010 supplemental proposed rule (75 FR 30973), we proposed to amend §§ 412.230, 412.232,

and 412.234 to reflect the average hourly wage reclassification criteria restored by section 3137(c) of the Affordable Care Act.

Comment: Several commenters urged CMS to use its administrative discretion to open an additional short window of opportunity for FY 2011 reclassification application. The commenters stated that some hospitals did not meet the average hourly wage criteria in effect as of the September 1, 2009 deadline, and, therefore, did not apply for reclassification for FY 2011; however, they meet the revised criteria and should be allowed a fair and equitable opportunity to reclassify. The commenters suggested that only a fairly limited number of hospitals would apply, so the workloads for CMS and the MGCRB should be manageable.

Response: As we discussed above, the deadline for application for reclassification is established through statute, under section 1886(d)(10) of the Act. Therefore, we believe that if the Congress had intended for hospitals to be afforded another opportunity to apply for reclassification for FY 2011 due to the revisions made by section 3137(c) of the Affordable Care Act, the Congress also would have established such opportunity through a provision of the law. We also believe that the commenters may have underestimated the workload and time required for the suggested additional window of opportunity and that such opportunity, instead, would have been very disruptive to the development and publication of the IPPS proposed and final rates for FY 2011. Given the amount of time it would have taken after the March 23, 2010 enactment date of the law for CMS to (1) Establish and implement a process for the additional application period, (2) allow hospitals sufficient time to submit their applications to the MGCRB, and (3) allow a sufficient period of time for the MGCRB to review the applications and make its decisions, the additional reclassifications would not have been determined in time for inclusion in the FY 2011 IPPS/LTCH PPS proposed rule or the supplemental proposed rule, and there would not be sufficient time to gather and consider comments regarding the effects of this application period on other nonreclassified hospitals as well as the hospitals that were able to take advantage of the second window for application.

We believe that our proposed implementation of section 3137(c) is the least disruptive and intended approach. Therefore, we are adopting our proposal as final in this FY 2011 IPPS/LTCH PPS final rule. The wage index in the Addendum to this final rule reflects the reclassifications that resulted from the Administrator's reversal of the MGCRB's decision for 22 hospitals that applied by September 1, 2009 and meet the revised average hourly wage criteria. In addition, we are adopting as final, without modification, the proposed revisions to §§ 412.230, 412.232, and 412.234 of the regulations to codify the revised average hourly wage criteria.

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 and incorporated this policy in our regulation at § 412.64(e)(4). Specifically, the regulations specified 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, we would transition from a nationwide adjustment to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010.

These policies for the rural and imputed floors were adopted in the FY 2009 IPPS final rule and were reflected in the proposed wage index in the Addendum to the FY 2011 IPPS/LTCH PPS proposed rule, published in the **Federal Register** on May 4, 2010 (75 FR 23937 and 23938). However, as we discussed in the June 2, 2010 supplemental FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30920), these policies were recently changed by the provisions of section 3141 of the Affordable Care Act. Specifically, section 3141 of the Affordable Care Act rescinded our policy that established a statewide budget neutrality adjustment for the rural and imputed floors and, instead, restored a uniform, national adjustment to the area wage index, beginning with the FY 2011 wage index.

In addition, we note that the imputed floor is set to expire on September 30, 2011. As we indicated in the supplemental proposed rule, we are not reading the language of section 3141 of the Affordable Care Act as altering this expiration date. Section 3141 of the Affordable Care Act requires that the Secretary "administer subsection (b) of such section 4410 and paragraph (e) of * * * section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index)." Thus, section 3141 of the Affordable Care Act is governing how we apply budget neutrality, under the authorities of § 412.64(e) and section 4410(b) of the Balanced Budget Act, but it does not alter § 412.64(h) of our regulations (which includes the imputed floor and its expiration date). To the extent there is an imputed floor, section 3141 of the Affordable Care Act governs budget neutrality for that floor, but it does not continue the imputed floor beyond the expiration date already included in our regulations.

In the FY 2011 IPPS/LTCH PPS supplemental proposed rule issued in the **Federal Register** on June 2, 2010, we proposed to revised the regulations at § 412.64(e) to reflect the changes made by section 3141 of the Affordable Care Act that restored a uniform, national adjustment to the area wage index, beginning with the FY 2011 wage index. We did not propose any other special rules or procedures for implementing the provisions of section 3141.

Comment: A few commenters favored the provision of section 3141 to restore the national adjustment to the wage index; other commenters objected to the provision.

Response: We appreciate the support of the commenters. Regarding the comment objecting to the provision, we are obligated to implement the provisions of the law.

In accordance with the law, we are adopting as a final policy in this final rule, a uniform, national budget neutrality adjustment for the rural and imputed floors, which, for FY 2011, is a factor of 0.996641. The wage index in the Addendum to this final rule reflects this policy. In addition, we are adopting as final, without modification, the proposed changes to § 412.64(e) of the regulations to incorporate the restoration provisions of section 3141 of the Affordable Care Act.

3. Floor for Area Wage Index for Hospitals in Frontier States

Section 10324(a)(1) of the Affordable Care Act amended section 1886(d)(3)(E) of the Act by adding a provision under new subsection (iii) to establish an adjustment to create a wage index floor of 1.00 for all hospitals located in States determined to be "frontier States," beginning in FY 2011. The new section 1886(d)(3)(E)(iii)(II) of the Act defines a "frontier State" as a State in which at least 50 percent of the counties in the State are determined to be "frontier

counties." The new section 1886(d)(3)(E)(iii)(III) of the Act defines a "frontier county" as a county in which the population per square mile is less than 6 persons. The new section 1886(d)(3)(E)(iii)(IV) of the Act specifies that this provision for the frontier State floor shall not apply to hospitals that are receiving a nonlabor-related share adjustment under section 1886(d)(5)(H) of the Act, that is, hospitals in Alaska or Hawaii.

To implement the provision for the frontier State floor adjustment, in the FY 2011 IPPS/LTCH PPS supplemental proposed rule published in the **Federal Register** on June 2, 2010 (75 FR 30920), we proposed to identify frontier Counties by analyzing population data and county definitions based upon the most recent annual Population Estimates published by the U.S. Census Bureau. We proposed to divide each county's population total by each county's reported land area (according to the decennial census) in square miles to establish population density. We also proposed to update this analysis from time to time, such as upon publication of a subsequent decennial census and, if necessary, add or remove qualifying States from the list of frontier States based on the updated analysis.

In accordance with section 1886(d)(3)(E)(iii) of the Act, as added by section 10324(a)(1) of the Affordable Care Act, all PPS hospitals located within a State that qualifies as a frontier State will receive either the higher of its post-reclassification wage index rate, or a wage index with a minimum value of 1.00. In the June 2, 2010 supplemental proposed rule, we proposed that, for a hospital that is geographically located in a frontier State and is reclassified under section 1886(d)(10) of the Act to a CBSA in a non-frontier State, the hospital would receive a wage index that is the higher of the reclassified area wage index or the minimum wage index of 1.00. In accordance with section 10324(a)(2) of the Affordable Care Act, the frontier State adjustment will not be subject to budget neutrality under section 1886(d)(3)(E) of the Act, and will only be extended to hospitals geographically located within a Frontier State. In the June 2, 2010 supplemental proposed rule, we proposed to calculate and apply the frontier State floor adjustments after rural and imputed floor budget neutrality adjustments are calculated for all labor market areas, so as to ensure that no hospital in a Frontier State will receive a wage index of less than 1.00 due to the rural and imputed floor adjustment. We invited public comment on these proposals regarding our methods for determining frontier States, and for calculation and application of the adjustment.

In the June 2, 2010 supplemental proposed rule (75 FR 30971), we proposed to establish a new paragraph (m) under § 412.64 to incorporate the provisions of section 1886(d)(3)(E)(iii) of the Act, as added by section 10324(a)(1) of the Affordable Care Act.

Comment: Commenters supported the proposed methods for implementation of the frontier States floor adjustment to the area wage index provided for under section 1886(d)(3)(E)(iii) of the Act.

Response: We appreciate the commenters' support.

In this final rule, we are implementing the frontier State floor adjustment using the criteria described above that we are finalizing in this final rule. For the final FY 2011 IPPS wage indices, based on the criteria described above, we identified the following frontier States that will receive the floor adjustment for FY 2011. These frontier States also are identified by a footnote in Table 4D–2 of the Addendum to this final rule.

FRONTIER STATES IDENTIFIED FOR THE FY 2011 WAGE INDEX FLOOR ADJUSTMENT UNDER SECTION 10324(a) OF THE AFFORDABLE CARE ACT

State	Total counties	Frontier counties	Percent of counties identified as frontier
Montana	56	45	80
Wyoming	23	17	74
North Dakota	53	36	68
Nevada	17	11	65
South Dakota	66	34	52

Figures in table based on:
—Population Data set available at: *http://www.census.gov/popest/estimates.html* (2009 County Total Population Estimates).
—Land Area Dataset available at: *http://factfinder.census.gov/* (Decennial Census Geographic Comparison Tables: "United States—County by State and for Puerto Rico").

After consideration of the public comments we received, we are adopting as final, without modification, the proposed addition of new paragraph (m) under § 412.64 of the regulations to incorporate the provisions of section 1886(d)(3)(E)(iii) of the Act, as added by section 10324(a)(1) of the Affordable Care Act, by specifying the criteria for adjusting the wage index to account for the frontier State floor adjustment, the amount of the wage index adjustment, and our process for determining and posting the wage index adjustments.

4. Plan for Reforming the Wage Index Under Section 3137(b) of Affordable Care Act

As we discussed in the June 2, 2010 supplemental proposed rule (75 FR 30919), section 3137(b) of the Affordable Care Act requires the Secretary of Health and Human Services to submit to Congress, not later than December 31, 2011, a report that includes a plan to reform the Medicare wage index applied under the Medicare IPPS. In developing the plan, the Secretary of Health and Human Services must take into consideration the goals for reforming the wage index that were set forth by MedPAC in its June 2007 report entitled, "Report to Congress: Promoting Greater Efficiency in Medicare", including establishing a new system that—

- Uses Bureau of Labor of Statistics (BLS) data, or other data or methodologies, to calculate relative wages for each geographic area;
- Minimizes wage index adjustments between and within MSAs and statewide rural areas;
- Includes methods to minimize the volatility of wage index adjustments while maintaining budget neutrality in applying such adjustments;
- Takes into account the effect that implementation of the system would

have on health care providers and on each region of the country;

• Addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

• Provides for a transition.

In addition, section 3137(b)(3) of the Affordable Care Act requires the Secretary of Health and Human Services to consult with relevant affected parties in developing the plan. Although the provisions of section 3137(b) of the Affordable Care Act will not have an actual impact on the FY 2011 wage index, we notified the public of the provisions in the supplemental proposed rule so that they would have an opportunity to provide comments and suggestions on how they may participate in developing the plan.

Comment: A few commenters encouraged CMS to involve the industry in the process. One commenter in particular suggested that CMS should adopt an advisory commission approach in addressing future changes to the wage index.

Response: We will consider these suggestions in developing our plan for meeting the requirements of section 3137(b) of the Affordable Care Act.

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 the FY 2011 proposed rule, we proposed to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we proposed to determine a wage index for FY 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".

We received one public comment on the proposed rule that commended CMS for continuing to incorporate OMB changes to the geographic area definitions used under the IPPS. CMS will apply these changes to the IPPS beginning October 1, 2010.

D. Occupational Mix Adjustment to the 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 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 FY 2011 hospital wage index, we used data from the 2007–2008 survey (including revised data for 45 hospitals) to compute the 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 FY 2011 wage index in this final 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.

Although, in the FY 2011 proposed rule, we did not propose any changes or solicit comments pertaining to the 2010 occupational mix survey, we received one comment that commended CMS for its decision to provide for a calendar year reporting period and a submission deadline that is 6 months after the end of the reporting period. The commenter believed that this timeframe will increase both the survey's accuracy and submission rate.

3. Calculation of the Occupational Mix Adjustment for FY 2011

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The FY 2011 occupational mix adjusted national average hourly wage is $34.9664.

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

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above. The FY 2011 occupational mix adjusted Puerto Rico-specific average hourly wage is $14.7620.

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

Hospital B									
			Step 1	Step 2	Step 3	Step 5	Step 6	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	in Step 7	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 FY 2011 wage index. For the FY 2007–2008 survey, the response rate was 91.1 percent.

In computing the 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. This method has 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 occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's 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 0.9249 (CBSA 17780, College Station-Bryan, TX), to a high of 1.1196 (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 five CBSAs (that include six 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. (See 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.

In the FY 2011 proposed rule, we stated that, in order to gain a better understanding of why some hospitals are not submitting the occupational mix data, we will require hospitals that do not submit occupational mix data to provide an explanation for not complying. This requirement will be effective beginning with the new 2010 occupational mix survey (the 2010 survey is discussed in section III.D.2. of this preamble). We will instruct fiscal intermediaries/MACs to begin gathering 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.

Comment: One commenter stated that it is unfair that some hospitals do not submit occupational mix data, while others consistently submit their data. The commenter also stated that there are presently no incentives for hospitals to submit occupational mix data, but praised CMS for beginning to take steps to address the issue by proposing to require hospitals that do not submit the data to provide an explanation for their noncompliance. The commenter suggested that CMS should still implement some kind of penalty in the form of a negative percentage adjustment to hospitals that do not submit occupational mix data, similar to what is done with hospitals that fail to submit quality data, in order to provide a greater motivation for hospitals to submit their occupational mix data.

Response: We appreciate this comment and will consider it as we continue to monitor and assess how to address hospitals' failure to submit occupational mix data for the wage index.

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

The final 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 final 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 (PRM, Part II, section 3605.2) 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 2010, the final wage index for FY 2011 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 final 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 final 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 June 22, 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 intended 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. The data for none of the hospitals identified in the proposed rule were resolved. However, the data for three additional hospitals were identified as too aberrant to include in the final wage index. Therefore, we determined that the data for 17 hospitals (that is, 14+3=17) should not be included in the FY 2011 final wage index.

In constructing the final 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 final rule, we removed 11 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 final FY 2011 wage index is calculated based on 3,511 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 FY 2011 wage index in this final 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 final rule.

G. Method for Computing the Final FY 2011 Unadjusted Wage Index

The method used to compute the FY 2011 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the final 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, 2004, through April 15, 2006, 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 making 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

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
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 final national average hourly wage (unadjusted for occupational mix) is $34.9895.

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 final average hourly wage (unadjusted for occupational mix) of $14.7404 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. The areas affected by this provision are identified in Table 4D–2 of the Addendum to this final rule.

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

H. Analysis and Implementation of the Final Occupational Mix Adjustment and the Final FY 2011 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2011, we are applying the occupational mix adjustment to 100 percent of the final FY 2011 wage index. We calculated the final 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 final FY 2011 wage index results in a final national average hourly wage of $34.9664 and a final Puerto Rico-specific average hourly wage of $14.7620. 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 final FY 2011 wage index, we calculated the final FY 2011 wage index using the occupational mix survey data from 3,197 hospitals. Using the Worksheet S–3 cost report data of 3,511 hospitals and occupational mix survey data from 3,197 hospitals represents a 91.1 percent survey response rate. The final 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	$36.073112086
National LPN and Surgical Technician	20.866432497
National Nurse Aide, Orderly, and Attendant	14.619357374
National Medical Assistant	16.479254498
National Nurse Category	30.47379669

The final national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $30.47379669. 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 44.29 percent, and the national percentage of hospital employees in the all other occupations category is 55.71 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 final FY 2011 occupational mix adjusted wage indices for each CBSA to the final unadjusted wage indices for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the final wage index values for 206 (52.7 percent) urban areas and 32 (68.1 percent) rural areas would increase. One hundred six (27.1 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 185 (47.3 percent) urban areas and 15 (31.9 percent) rural areas would decrease. Eighty nine (22.8 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 7.81 percent for an urban area and 2.97 percent for a rural area. The largest negative impacts are 3.97 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 (52.7 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 final 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 final rule include the final occupational mix adjustment.

Tables 3A and 3B in the Addendum to this final rule list the 3-year average hourly wage for each labor market area before the redesignation 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 final 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 final 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 final average hourly wages in Tables 2, 3A, and 3B in the Addendum to this final rule include the final occupational mix adjustment. The final wage index values in Tables 4A, 4B, and 4C also include the final State-specific rural floor and imputed floor budget neutrality adjustments. (We note that Table 4D–1, Rural Floor Budget Neutrality Factors for Acute Care Hospitals, was included in the Addendum to the FY 2011 IPPS/LTCH PPS proposed rule. However, we are not including it in this final rule because section 3141 of the Affordable Care Act restores rural floor and imputed floor budget neutrality to a uniform national adjustment.)

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.

Comment: One commenter opposed CMS' longstanding methodology for calculating the wage index for reclassified hospitals, and suggested that CMS calculate a separate reclassified wage index for those hospitals that meet the reclassification proximate requirement and another wage index for those hospitals that do not meet the requirement. In addition, the commenter suggested another option which would provide for calculation of the reclassified wage index based on the hospitals physically located in the CBSA and each individual hospital, instead of combining all reclassified hospitals as a group.

Response: We did not include any proposals in the FY 2011 proposed rule to change our longstanding methodology for calculating the wage index for reclassified hospitals. We believe that this methodology continues to be appropriate in order to calculate the wage index for hospitals for Medicare payment purposes.

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 final rule was constructed, the MGCRB had completed its review of FY 2011 reclassification requests. Based on such reviews, there were 285 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 247 hospitals approved for wage index reclassifications in FY 2009 and 251 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 final rule, 823 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 had to be received by the MGCRB within 45 days of the publication of the FY 2011 proposed rule. Hospitals also could 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 are incorporated into the wage index values published in this 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, this section of the regulations did not address Administrator review of the MGCRB's denial of a hospital's request for termination; that is, "terminations" not specified in the regulations at § 412.273(e).

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23949), we proposed 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 stated our belief that 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 and proposed to revise the provision accordingly.

We did not receive any public comments regarding our proposed changes to the regulations at § 412.273. Therefore, in this final rule, we are adopting as final, without modification, the proposed changes to § 412.273.

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
Oceana, MI	Muskegon-Norton Shores, MI
Shiawassee, MI	Lansing-East Lansing, MI
Tuscola, MI	Saginaw-Saginaw Township North, MI

Rural County	CBSA
Fillmore, MN	Rochester, MN
Dade, MO	Springfield, MO
Pearl River, MS	Gulfport-Biloxi, MS
Caswell, NC	Burlington, NC
Davidson, NC	Greensboro-High Point, NC
Granville, NC	Durham, NC
Harnett, NC	Raleigh-Cary, NC
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC
Polk, NC	Spartanburg, SC
Los Alamos, NM	Santa Fe, NM
Lyon, NV	Carson City, NV
Cayuga, NY	Syracuse, NY
Columbia, NY	Albany-Schenectady-Troy, NY
Genesee, NY	Rochester, NY
Greene, NY	Albany-Schenectady-Troy, NY
Schuyler, NY	Ithaca, NY
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY
Wyoming, NY	Buffalo-Niagara Falls, NY
Ashtabula, OH	Cleveland-Elyria-Mentor, OH
Champaign, OH	Springfield, OH
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA
Cotton, OK	Lawton, OK
Linn, OR	Corvallis, OR
Adams, PA	York-Hanover, PA
Clinton, PA	Williamsport, PA
Greene, PA	Pittsburgh, PA
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ
Schuylkill, PA	Reading, PA
Susquehanna, PA	Binghamton, NY
Clarendon, SC	Sumter, SC
Lee, SC	Sumter, SC
Oconee, SC	Greenville, SC
Union, SC	Spartanburg, SC
Meigs, TN	Cleveland, TN
Bosque, TX	Waco, TX
Falls, TX	Waco, TX
Fannin, TX	Dallas-Plano-Irving, TX
Grimes, TX	College Station-Bryan, TX
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA

Rural County	CBSA
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 were permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to the proposed rule into which they would be reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals could have withdrawn from an MGCRB reclassification within 45 days of the publication of the FY 2011 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 the requirements of section 3137(c) of the Affordable Care Act, as discussed in section III.B.2.a of the preamble in this final rule, beginning with reclassifications for the FY 2011 wage index, a Lugar hospital must also demonstrate that its average hourly wage is equal to at least 82 percent 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 2010 notice issued in the **Federal Register** on June 2, 2010 (75 FR 31118). Prior to the enactment of the Afforable Care Act, the extension of the 508 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. The most recent extension of the provision was included in sections 3137(a) and 10317 of Affordable Care Act, as amended. Section 3137(a) of the Affordable Care Act, as amended by section 10317, extended, through FY 2010, section 508 reclassifications as well as certain special exceptions. Because the latest extension of these provisions expires on September 30, 2010, and will not be applicable in FY 2011, we are not making any changes related to these provisions in this final rule.

J. 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 final FY 2011 wage index, we calculated the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

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

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

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

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

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 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 are deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wished to receive the out-migration adjustment, rather than their reclassification adjustment, were instructed to follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of the FY 2011 proposed rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act were deemed to have waived the out-migration adjustment unless they explicitly notified CMS within 45 days from the publication of the FY 2011 proposed rule that they elected to receive the out-migration adjustment instead.

Table 4J in the Addendum to this final rule lists the out-migration wage index adjustments for FY 2011. Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act automatically receive the listed adjustment. In accordance with the procedures discussed above, redesignated/reclassified hospitals were deemed to have waived the out-migration adjustment unless CMS was otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdrew their application for reclassification will automatically receive the wage index adjustment listed in Table 4J in the Addendum to this final rule. The wage index is updated annually and, as such, hospitals that wish to waive their Lugar redesignation in order to receive their home area wage index plus the out-migration adjustment must request the waiver annually.

Comment: A few commenters opposed our existing policy that hospitals waiving their Lugar redesignation in order to receive their home area wage index plus the out-migration adjustment must request such waiver annually.

Response: We did not propose to change this policy and continue to believe the existing policy is appropriate for designation of the out-migration adjustment annually. We addressed this comment in the FY 2010 IPPS/RY 2010 LTCH PPS final rule and refer readers to that discussion (74 FR 43840).

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 were required 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 was April 21, 2010.

Hospitals were given the opportunity to examine Table 2 in the Addendum to the proposed rule. Table 2 in the Addendum to the proposed rule contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2007 data used to construct the proposed FY 2011 wage index. We noted that the hospital average hourly wages shown in Table 2 only reflected changes made to a hospital's data and transmitted to CMS by March 2010.

We released the final wage index data public use files in early May 2010 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage.* The May 2010 public use files were made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary/MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the fiscal intermediaries/MACs by April 14, 2010). If, after reviewing the May 2010 final files, a hospital believed that its wage or occupational mix data were incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital had to send a letter to both its fiscal intermediary/MAC and CMS that outlined why the hospital believed an error exists and provided all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) had to receive these requests no later than June 7, 2010.

Each request also had to be sent to the fiscal intermediary/MAC. The fiscal intermediary/MAC reviewed requests upon receipt and contacted CMS immediately to discuss any findings.

At this point in the process, that is, after the release of the May 2010 wage index data files, changes to the wage and occupational mix data were only made in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS approved the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 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) were incorporated into the final wage index in this 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 calculated 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 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23955), we did not propose 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).

We did not receive any public comments on this policy. Therefore, for FY 2011, we are continuing 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 final rule reflects this 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 national wage index for all Puerto Rico hospitals is less than 1.0. As we proposed, in this final rule, we are continuing 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 percent, 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. We did not receive any public comments on the Puerto Rico-specific labor-related share. The Puerto Rico labor-related share of 62.1 percent for FY 2011 is reflected in the Table 1C of the Addendum to this final rule.

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

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

1. Background

a. Overview

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

CMS has implemented quality measure reporting programs for multiple settings of care. 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. In implementing RHQDAPU and other quality reporting programs, CMS has focused on measures that have high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. Our goal for the future is to align the clinical quality measure requirements of RHQDAPU and various other programs including HITECH so that burden for reporting would be reduced.

Comment: Some commenters commended CMS' commitment to raise quality, transparency, and efficiency in the health care world and applauded its efforts to integrate with other programs and initiatives.

Response: We thank these comments regarding our implementation of the RHQDAPU program.

Comment: A commenter noted that the proposed rule did not reference the quality-related provisions of the Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (HCERA) (Pub. L. 111–152). The Affordable Care Act requires the Secretary to establish a national quality strategy to include priorities and goals for quality improvement with input from stakeholders, such as the NQF.

Response: The timing of the FY 2011 IPPS/LTCH PPS proposed rule did not allow us to address the many quality-related provisions of the Affordable Care Act. The Affordable Care Act modified the RHQDAPU statutory provisions, authorized the Secretary to implement quality-related programs for various settings of care, and also added new requirements for collaborative goal setting regarding quality (as noted by the commenter). The focus of this specific section of this final rule is the RHQDAPU program, and we are addressing changes to the RHQDAPU program under the Affordable Care Act in this final rule. We plan to propose requirements for the Hospital Value-Based Purchasing (HVBP) program (section 3001 of Affordable Care Act) and other quality-related Affordable Care Act provisions through future rulemaking. Additionally, section 3011 of the Affordable Care Act requires the Secretary to establish and update a national strategy to improve the delivery of health care services, patient health outcomes and population health. The initial submission of the national strategy to Congress must be no later than January 1, 2011. The national strategy as directed by section 3011 is broader in scope than hospital inpatient services, which are the focus of the RHQDAPU program. However, the national strategy may include guidance for future RHQDAPU program implementation.

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 as added by the DRA 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 4102(b)(1)(A) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) and section 3401(a)(2) of the Affordable Care Act (Public Law 111–148) amended section 1886(b)(3)(B)(viii)(I) of the Act to provide that, beginning in FY 2015, the reduction will be by one-quarter of such applicable percentage increase (determined without regard to reductions under sections 1886(b)(3)(B)(ix), (xi), or (xii) of the Act).) 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 before it was amended by the American Recovery and Reinvestment Act and the Affordable Care Act.

d. Hospital Quality Data Reporting Under Sections 3001(a)(2) and 3401(a)(2) of Public Law 111–148

Section 3001(a)(2) of the Affordable Care Act, Public Law 111–148, amended section 1886(b)(3)(B)(viii) of the Act. Specifically, section 3001(a)(2)(A) of the Affordable Care Act amended section 1886(b)(3)(B)(viii)(II) of the Act to state that the Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under the HVBP program. Section 3001(a)(2)(C) of the Affordable Care Act amended section 1886(b)(3)(B)(viii)(VII) of the Act to require that the Secretary establish procedures for making information regarding measures submitted (instead of data submitted) available to the public. In addition, section 3001(a)(2)(B) of the Affordable Care Act amended section 1886(b)(3)(B)(viii)(V) of the Act to limit the requirement that measures added by the Secretary reflect consensus among affected parties and, to the extent feasible and practicable, include measures set forth by one or more national consensus building entities to payments for FYs 2008 through 2012.

Section 3001(a)(2)(D) of the Affordable Care Act added section 1886(b)(3)(B)(viii)(IX) of the Act to require, for payments beginning with FY 2013, each measure specified by the Secretary under section 1886(b)(3)(B)(viii) of the Act to be endorsed by the entity with a contract under section 1890(a) regarding consensus entities (the "consensus entity") except, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus entity, the Secretary may specify a measure that is not endorsed so long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

Section 3001(a)(2)(D) of the Affordable Care Act also added new sections 1886(b)(3)(B)(viii)(VIII), 1886(b)(3)(B)(viii)(X) and 1886(b)(3)(B)(viii)(XI) to the Act, which require the Secretary to do the following, respectively: (1) Provide for such risk adjustment as the Secretary determines appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions with respect to quality measures for outcomes of care effective for payments beginning with FY 2013; (2) to the extent practicable and with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under 1886(b)(3)(B)(viii) of the Act are coordinated and aligned with quality measures applicable to physicians under section 1848(k) of the Act and other providers of services and suppliers under Medicare; and (3) establish a process to validate measures specified under section 1886(b)(3)(B)(viii) of the Act, which includes the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

Additionally, section 3401(a)(2) of the Affordable Care Act amended section 1886(b)(3)(B)(viii)(I) of the Act by adding the phrase "of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))" after the word "one-quarter" so that, beginning in FY 2015, the reduction under the RHQDAPU program will be by one-quarter of such applicable percentage increase determined without regard to other reductions in the annual payment update set forth in sections 1886(b)(3)(B)](ix), (xi), or (xii) of the Act.

e. 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.[10]

Section 1886(b)(3)(B)(viii)(V) of the Act, as amended by section 3001(a)(2)(B) of the Affordable Care Act, requires that, effective for payments for FYs 2008 through 2012, 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,

[10] 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.

including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment.

As discussed previously, section 3001(a)(2) of the Affordable Care Act amended section 1886(b)(3)(B)(viii) of the Act to provide a different standard for quality measures included in the RHQDAPU program for payments beginning with FY 2013. Under section 1886(b)(3)(B)(viii)(IX) of the Act, for payments beginning with FY 2013, each measure specified by the Secretary must be endorsed by a consensus entity, currently NQF, except in certain circumstances. Specifically, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus entity, the Secretary may specify a measure that is not endorsed by the consensus entity if due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

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 6 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 1 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 2 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 FY 2009 IPPS final rule (73 FR 46809) and in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68781).

On December 31, 2008, we 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. We 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 (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 2 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 2chart-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 2 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 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 the 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
	• 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

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination as Finalized in the FY 2010 IPPS/RY 2010 LTCH PPS Final Rule
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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f. 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.

We did not receive any public comments on this section and we will continue to use this process to maintain the technical specifications for the RHQDAPU program measures.

g. Public Display of Quality Measures

Section 1886(b)(3)(B)(viii)(VII) of the Act, as amended by section 3001(a)(2) of the Affordable Care Act, requires that the Secretary establish procedures for making information regarding measures submitted 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 relevant 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.*

Comment: One commenter supported CMS' current policy of identifying quality measures rates based on fewer than 25 cases as potentially unreliable for judging a hospital's performance when displaying data on *Hospital Compare.* The commenter indicated that this is currently accomplished by footnoting the data but it would be better to simply not display the rates that are based on fewer than 25 cases.

Response: We thank the commenter for the suggestion. Although data display and Web site design issues are not subject to the rulemaking process, we will take this suggestion under consideration for future releases of the *Hospital Compare* Web site.

Comment: One commenter requested that CMS describe in greater detail the rationale for publicly reporting measures on CMS Web sites other than *Hospital Compare* on a case-by-case basis.

Response: Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making information regarding measures submitted for the RHQDAPU payment determinations available to the public after ensuring that a hospital has the opportunity to review its data before they are made public. While we strive to make as much of this information available on the *Hospital Compare* Web site, there are instances where we need further time to develop a method of displaying the information so that it does not confuse or mislead consumers intending to use the data in healthcare decision making. To satisfy the statutory requirement for transparency of the information used to make RHQDAPU payment determinations available to the public, we would display the data on another CMS Web site such as *http://www.cms.gov,* but not on the *Hospital Compare* Web site, which is meant to be a consumer oriented decision tool. Once an appropriate display mechanism has been determined, the information would be added to the *Hospital Compare* Web site.

We will continue to use this public display process for the RHQDAPU program.

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 sets. 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 (74 FR 43864 and 43865), 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 e-mail 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 invited commenters to submit suggestions for additional measure retirement criteria for CMS to consider.

Comment: One commenter asked for the CMS definition of "retirement" and the relationship of retired measures to the RHQDAPU program.

Response: Retirement of a measure from the RHQDAPU program constitutes permanent removal of a measure from the RHQDAPU program measurement set for future payment determinations.

Comment: Some commenters agreed with CMS' quality measure retirement criteria including measures with consistent high performance (topped-out), measures not supported by evidence, measures that no longer represent the best clinical practice, and measures that have become a cause for potential patient safety concerns. A commenter recommended that CMS add the following two criteria to its list of criteria to be considered when determining whether to retire a RHQDAPU measure: (1) The measure should be modified or deleted if new clinical evidence exists that demonstrates that the measure should be modified or deleted; and (2) a previous process measure should be retired in favor of a new risk-adjusted outcomes measure. Some commenters

suggested CMS collaborate with organizations such as the NQF and the HQA in reviewing all current RHQDAPU quality measures for retirement determinations.

A few commenters supported the retirement of topped-out measures but some commenters were concerned that the retirement of topped-out measures would lead to subsequent declining performance. The commenters further suggested that the process measures are also accountability measures and should not be retired just because they are topped-out. Some commenters recommended that CMS should continue data collection for topped out measures on a 3-year cycle, or consider incorporating the measure into a meaningful composite measure set. Another commenter recommended that CMS conduct demonstration projects to ascertain the impact of the proposed measures for retirement and assess the organizations' ability to sustain improvement over time for measures that are considered to be taken out of the RHQDAPU program. The commenter believed that demonstration projects would enable the cycling of measures in and out of the RHQDAPU program as desired for public reporting and incentive payment programs.

Response: We thank the commenters for sharing these suggestions and criteria for quality measure retirement. We will consider the commenters' recommendations for evaluating current RHQDAPU program measures for retirement. We agree that changing scientific evidence should be considered in deciding whether to modify or retain a measure. We also agree that risk-adjusted outcome measures could potentially serve to replace process measures, although we believe other factors should be considered such as the performance on the process measures and the degree to which the measures address the same populations. While sustaining quality improvement gains for measures is important, it currently is not feasible for us to conduct continued surveillance on measures that have been retired from the RHQDAPU program. Further, we do not believe that the one measure that we have retired requires continued surveillance. This is because measuring oxygen saturation is part of ongoing monitoring functions built into equipment used for all hospitalized patients, and therefore would not suffer a decline in practice from lack of inclusion in this reporting program. We will consider the feasibility of the commenters' suggestions to periodically monitor performance of measures that we may subsequently retire. As for collaboration with NQF and HQA, we consider changes in NQF endorsement status for measures adopted and considered for RHQDAPU, and as HQA members, we participate in HQA activities, which include reviewing measures which may be considered for retirement. We will consider the feasibility and appropriateness of the suggestion to use Medicare demonstrations as a potential mechanism to monitor measure performance for measures that may in the future be retired from the RHQDAPU program and suffer a decline in desired practices as a result of retirement.

b. 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 [11] that this composite is "not recommended for comparative reporting" as specified due to significant evidence gaps, and that these significant evidence gaps are 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 proposed to retire the Mortality for Selected Procedures Composite 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 invited 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 invited commenters to submit suggestions and rationales for retirement of other RHQDAPU program measures.

Comment: Commenters overwhelmingly supported the proposed retirement of the Mortality for Selected Procedures Composite from the RHQDAPU program measure set for the FY 2011 payment determination and for subsequent payment determinations due to its unsuitability for comparative reporting.

Response: We thank the commenters for their support and we are finalizing the retirement of this measure for the FY 2011 and subsequent payment determinations.

Set out below are the 45 RHQDAPU program quality measures for the FY 2011 payment determination reflecting our retirement of 1 measure:

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[11] 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.*

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting 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
	• 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

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting Retirement of One Measure
	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. 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. In addition, in selecting measures, we seek to address the six quality aims of effective, safe, timely, efficient, patient-centered, and

equitable healthcare. Current and long term priority topics include: prevention and population health; safety; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other adverse healthcare outcomes; improved care coordination; improved efficiency; improved patient and family experience of care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable health information technology.

These criteria, priorities, and goals are consistent with section 1886(b)(3)(B)(viii)(X) of the Act, as added by section 3001(a)(2)(D) of the Affordable Care Act, which requires the Secretary, to the extent practicable and with input from consensus organizations and other stakeholders, to take steps to ensure that the RHQDAPU measures are coordinated and aligned with quality measures applicable to physicians and other providers of services and suppliers under Medicare.

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 claims-based and structural measures, we previously noted that registries [12] 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 (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.

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 retired for the FY 2011 payment determination and subsequent payment determinations in this final 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 noted in the FY 2011 IPPS/LTCH PPS proposed rule that 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.

Comment: A few commenters supported the use of EHR-based data collection. One commenter was concerned that the clinical quality measures in the RHQDAPU program do not align with the electronic quality measure reporting requirements as part of the meaningful use criteria under the HITECH EHR incentive program rule.

Response: We appreciate these supportive comments for EHR-based data collection as an alternative data source for quality measures. One of our priorities in the RHQDAPU program is to align clinical quality measures in the RHQDAPU program with the electronic quality measure reporting requirements under the meaningful use criteria under the HITECH EHR Incentive program in the future, and to specify current RHQDAPU measures for EHR-based collection. We note that some of the RHQDAPU program quality measures do not lend themselves to EHR reporting, for example HCAHPS experience of care measures. We are mindful of the need for alignment of the clinical measures used in the two programs as more measures are implemented in the future.

Comment: Several commenters stated that CMS should delay the implementation of additional quality measures and spend time prioritizing future electronic quality measures during this transition to EHR.

Response: Given the time that will be needed for building of infrastructure, interoperability, testing and development of e-specifications of measures, and the proposal and finalization of clinical quality measures, we believe we should not wait for the complete transition to EHR-based measure collection in order to move forward with the expansion of the RHQDAPU program. In determining whether to adopt new quality measures for the RHQDAPU program, we weigh the potential benefit of improvement that would result from reporting a given measure against the potential resource burden associated with reporting a measure. However, in the future, our intent is to develop and specify electronic measures of quality that will be aligned and meet the requirements for both programs.

[12] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

Comment: One commenter questioned the value of claims-based and registry-based data collection when EHR data collection is fully implemented.

Response: We believe that claims may still be needed to identify prior events and diagnoses for measures that require look-back periods, involving the matching of data for a single patient over long periods of time (for example, 1 year of prior history) across multiple settings. EHR data provides a cross-sectional snapshot of data, and such matching is not possible with a snapshot of data from a single provider or setting because it would not have all events and diagnoses for a particular patient outside of the particular setting or episode of care. This is possible, however, when claims for Medicare beneficiaries are utilized for such historical information across providers. Such data could be used to supplement cross-sectional clinical EHR data. Furthermore, registries provide services beyond data collection, such as quality improvement support, feedback and best practices.

Comment: A commenter requested that CMS only implement measures that are aligned with identical technical specifications as other national data collection projects. For instance, the proposed Stroke registry measure has different population definitions from the Joint Commission stroke core measures, Disease certification program and designated Stroke Centers.

Response: We agree that measures used in the RHQDAPU program should be based on a single set of harmonized population definitions and measure specifications. As discussed in later sections, we are not finalizing the registry-based submission mechanism proposal.

Comment: One commenter asked for clarification on the requirements for measures that are calculated based on ICD–9 CM codes as well as the timeline and impact of transitioning to ICD–10–CM codes.

Response: CMS has announced the transition to ICD–10–CM codes effective October 1, 2013, at the start of FY 2014. Prior to that date, we will be respecifying measures that are implemented in quality data reporting programs to incorporate ICD–10–CM codes.

Comment: Several commenters noted that CMS' intent to reduce burden by proposing different reporting mechanism may in fact create more burden on hospitals. Hospitals are most familiar with chart abstraction.

Response: We agree with commenters that hospitals are most familiar with chart abstraction as a data collection method. However, we also recognize that this is a burdensome mechanism. Therefore, we believe, that it is desirable to leverage other collection mechanisms, especially where they are already actively being used by hospitals. We introduced two alternative reporting mechanisms in the proposed rule, the National Healthcare Safety Network (NHSN) and registry-based reporting. Although we are not adopting registry-based reporting, we envisioned that most hospitals would already be reporting one of the measures sets to at least one registry. Accordingly, we anticipated that in most cases there would be no new reporting required, only the selection of a registry to which hospitals were already reporting.

With respect to the NHSN, many States are introducing requirements that hospitals report HAI data to the Centers for Disease Control and Prevention (CDC) via NHSN. Although we could have required that hospitals report HAI measures to CMS via chart abstraction, this would require duplicate effort on the part of hospitals submitting data through the NHSN on HAIs. Therefore, we proposed and are finalizing the CDC NHSN as the mechanism to submit data on HAI measures. In this way, we have aligned the CDC reporting efforts, and reporting mandated by many States. We believe that this is good policy and something commenters have urged.

Comment: A number of commenters supported the use of registries as an alternative source of hospital-specific data on quality measures and as a means to reduce hospital burden. Several commenters indicated that the use of registries to collect hospital-level data would reduce administrative burden and ensure appropriate risk-adjustment for quality improvement and public reporting purposes, as well as other benefits, including broadening the information for quality improvement and *Hospital Compare,* but cautioned that registry data could weaken the validity and reliability of the information unless strict standards for data quality were imposed. A commenter suggested that CMS consider additional measures that could be compiled from registry data.

Response: We thank the commenters for acknowledging the potential efficiencies and quality improvement support that could be gained through registry-based quality data reporting. We agree that standards for data quality would be necessary should CMS adopt registry-based measures for RHQDAPU in the future. The qualification criteria we proposed for registries were meant to establish standards for data quality for the measures we proposed to receive from registries. We will continue to pursue registry-based data submission as an alternative mechanism for receiving data for quality measures adopted into the RHQDAPU measurement set.

Comment: Many commenters opposed the inclusion of quality measures that require participation in registries. Several commenters expressed concern regarding the possibility that they may be required to participate in proprietary registries in the future. These commenters saw registry-based data collection as costly and labor intensive because many of the measures collected by registries require chart abstraction. Some commenters recommended that CMS first standardize the data collection and submission process across registries to ensure data quality. One commenter asked for clarification on how would the registry-based measures which are only used by a subset of hospitals be utilized in a value based purchasing program. Some commenters encouraged CMS to promote the study of regional variation to enable comparisons within/across systems and among regional registries in order to give hospitals more options in data reporting.

Response: We are not finalizing the registry-based submission proposal. Among other reasons for not finalizing this proposal, we agree that it would be difficult to use the measures for value based purchasing if only a subset of hospitals with such cases report the measures, as the commenter suggests. Regional registries may be appropriate for registry-based submission, so long as there are a sufficient number of other registries to allow submission nationwide. We agree with the importance of standardizing data collection and submission processes by registries. Many hospitals are currently participating in a number of registries that collect data on quality measures that are topics of interest to us. We did not intend to require hospitals to participate in a proprietary registry, but rather to leverage existing participation in registries as an efficient alternative source from which to collect the data. However, we acknowledge the commenters' concern regarding the cost and labor associated with participation in certain registries which may make this alternative mechanism for data submission less feasible for some hospitals.

In considering registry-based submission for the future, we will consider whether registry-based data collection should be one means, but not an exclusive means, of submitting data for RHQDAPU quality measures.

Comment: Some commenters encouraged CMS to look to the National Priorities Partnership goals as a framework for the types of measures that should be included in the RHQDAPU program. Another commenter suggested the RHQDAPU program should only include those quality measures that meet a high threshold of accountability criteria. Another commenter stated CMS should develop a core measure set for inclusion in the pay-for-performance program.

Response: The National Priorities Partnership is a 28 member organization convened by the NQF for the purpose of identifying improvement goals and action steps for the U.S. healthcare system. We are a member of the National Priorities Partnership and participate in its framework-setting activity. Our measure selection activity and measure development activity takes into account the priorities established by this framework as well as other criteria described earlier. Since measure selection for the HVBP program is dependent upon the pool of measures that have been adopted for the RHQDAPU program, the measures to be selected for inclusion in the HVBP program would be guided by these same frameworks and criteria.

Comment: Several commenters stated that measures selected for the RHQDAPU program should be both endorsed by the NQF and adopted by the HQA. Some commenters suggested that these steps were required by the Deficit Reduction Act of 2005 (DRA).

Response: Section 1886(b)(3)(B)(viii)(V) of the Act, as added by the DRA and prior to the amendment made by section 3001(a)(2)(B) of the Affordable Care Act, requires that, effective for payments beginning with FY 2008, the Secretary add quality measures that reflect consensus among affected parties and, to the extent feasible and practicable, have been set forth by one or more national consensus building entities. This provision does not require that the measures we adopt for the RHQDAPU program be endorsed by any particular entity, and we believe that consensus among affected parties can be reflected by means other than endorsement by a voluntary consensus organization, including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment (74 FR 24165 through 24166). Nevertheless, we have stated on numerous occasions that we prefer quality measures that are endorsed by the NQF. The NQF uses a formal consensus development process. As the NQF notes on its Web site at: *http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx,* it has been recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113) (NTTAA) and Office of Management and Budget Circular A–119. We are unaware of any other organizations that qualify as an NTTAA consensus organization for the endorsement of quality measures.

We also take into consideration the measures adopted by the HQA as well as an array of input from the public. The HQA is a national public-private collaboration that is committed to making meaningful, relevant, and easily understood information about hospital performance accessible to the public and to informing and encouraging efforts to improve quality. We appreciate HQA's integral efforts to improve hospital quality of care and its support of our public quality reporting programs. As discussed previously, section 3001(a)(2) of the Affordable Care Act amended section 1886(b)(3)(B)(viii)(V) of the Act and limited its applicability effective for payments for FYs 2008 through 2012. However, section 3001(a)(2) of the Affordable Care Act added a new section 1886(b)(3)(B)(viii)(IX) to the Act. This provision requires, for payments beginning with FY 2013, that each measure specified by the Secretary be endorsed by a consensus entity, except in certain circumstances. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus entity, the Secretary may specify a measure that is not endorsed by the consensus entity if due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

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 RHQDAPU beyond those to be collected for the purpose of the next sequential payment determination. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23965), we proposed an expansion to the RHQDAPU program that will take place over 3 payment years, and proposed to add measures not only for the FY 2012 payment determination, but also for 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 to collect data on the measures and make payment determinations. Finally, in section IV.A.5.a.(2) of the proposed rule (75 FR 23985), we discussed 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 invited public comment on the measures and timeframe for their addition to the RHQDAPU program measure set.

Comment: Many commenters expressed support of our proposal to propose and finalize RHQDAPU quality measures for 3 years in a single rulemaking in order to provide hospitals with advanced notice for planning purpose.

Response: We appreciate the commenters' support of our proposal to finalize measures for 3 consecutive payment determinations. Although we will finalize measures for 3 consecutive years, we may add or remove measures for these years in future rulemaking cycles should we need to respond to agency and statutory changes.

Comment: A few commenters urged CMS not to finalize the proposed 3-year RHQDAPU quality measure plan until the availability of adequate information to align RHQDAPU program quality measures with the upcoming health care priorities of the Affordable Care Act becomes available. A commenter stated it is crucial to assure data quality given the various data sources that CMS proposed.

Response: We retain the ability to change or replace measures in future rulemaking, which could be based on the national strategy to be developed under the Affordable Care Act. The measures that we finalize reflect important HHS priorities. Establishing them as RHQDAPU measures allows hospitals, CMS, and the public to have a longer time to prepare for collection and quality improvement efforts related to the measure. We have also previously

stated that should agency priorities or legislative changes require us to alter the measures selected, we will do so through the rulemaking process. We intend to examine and assure data quality for new sources of data if adopted for RHQDAPU.

Comment: Some commenters questioned CMS' authority to add measures to the RHQDAPU program beyond the FY 2012 payment determination as section 3001(a)(2)(B) of the Affordable Care Act revises section 1886(b)(3)(B)(viii)(V) of the Act.

Response: We do not believe that the commenters are correctly reading the amendment to section 1886(b)(3)(B)(viii)(V) of the Act made by section 3001(a)(2)(B) of the Affordable Care Act in conjunction with section 1886(b)(3)(B)(viii)(III) of the Act. As amended, section 1886(b)(3)(B)(viii)(V) of the Act states that, for payments for FYs 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities. For payments for FY 2013 and beyond, the Secretary would be able to add measures because section 1886(b)(3)(B)(viii)(III) of the Act provides the Secretary with the authority to expand the measures consistent with the succeeding statutory provisions. Section 1886(b)(3)(B)(viii)(V) of the Act simply would not apply to payments for FYs 2013 and beyond.

In summary, we are finalizing our proposal to select measures for three consecutive payment years. As discussed in section IV.A.5.a.(2) of this final rule, where we respond to comments on synchronizing the quarterly submission of data, we are finalizing our proposal to synchronize the quarterly submission of data for RHQDAPU. We will continue to pursue goals regarding the expansion and updating of quality measures under the RHQDAPU program while minimizing burden. We will take into account the public comments we received on the possible uses of EHRs, registries, and all-payer claims data in the RHQDAPU program. We also will consider the measure selection criteria suggested by various commenters in prioritizing and selecting quality measures for the future.

b. RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

(1) Retention of 45 Existing RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

As noted above, we are retiring the AHRQ Mortality for Selected Surgical Procedures Composite for the FY 2011 payment determination. We proposed 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 were discussed in section IV.A.5. of the proposed rule. We invited 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.

Comment: A commenter suggested CMS further discuss risk-adjustment, co-morbid conditions, exclusion criteria, and interpretation of the collected data before making decisions to retain the 45 measures as proposed.

Response: In general, we retain measures from one payment determination to the next unless we specifically retire them. Currently, risk adjustment of comorbidities for outcome measures and exclusion criteria for all measures are maintained on an ongoing basis as part of routine measure maintenance, and are submitted every 3 years to NQF for reevaluation. We do not address measure maintenance or data display and interpretation issues in annual rulemaking. These issues are addressed in sub-regulatory processes.

Comment: Some commenters were concerned that the Pneumonia Measure PN·6 (including PN·6a and PN–6b) relating to the initial antibiotic selection for Community Acquired Bacterial Pneumonia (CABP) in immune-competent patients is at risk of not representing the best clinical practice if its technical specifications are not updated in a timely manner. The commenters suggested that, for PN–6, CMS should clearly define the process for hospitals to prescribe newly approved antibiotics to treat CABP with flexibility. Furthermore, the commenters noted that CMS also should add *Ceftaroline Fosamil* to the Pneumonia Antibiotic Consensus Recommendations upon FDA approval.

Response: As stated earlier, we maintain and update the technical specifications for RHQDAPU program measures regularly, which includes regular updating of drug lists to include new FDA approved medications, including antibiotics that could be used for patients included in the PN–6 measure. Appropriate documentation for hospital prescribing practices for measures such as PN–6 is also maintained in the technical specifications.

After consideration of the public comments we received, we are adopting as final our proposal to retain 45 existing measures from the FY 2011 RHQDAPU payment determinations as RHQDAPU quality measures for the FY 2012 payment determination.

In proposing to retain 45 of the 46 FY 2011 measures, we recognized that we were not significantly reducing the burden for hospitals, since the 1 measure that we proposed to remove is a measure that currently is calculated based on Medicare claims. At the same time, our proposal to expand the measures for FY 2012 and beyond 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 invited comments on the option to retire 1 or more of these 11 measures that were suggested for retirement by commenters to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. We acknowledged that some of these measures were proposed for electronic reporting under the program for incentive payment for meaningful use of electronic health records (75 FR 1896).

In addition, we stated that we were 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 option that we were considering would be retirement of 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 invited comments on this option to retire narrowly specified measures in order to accommodate more broadly specified measures on a given topic.

Comment: A few commenters supported retiring narrowly specified measures such as the vaccination measures that are specific to Pneumonia inpatients, as a way to reduce burden, especially when broader measures are available.

Response: We thank the commenters for their support of the concept of retiring narrowly specified measures and replacing them with measures that could be applied to a broader population. As we discuss below in section IV.A.3.d. of this final rule, we are using this strategy and retiring the pneumonia-specific immunization measures for the FY 2014 payment determination because we are adopting the global immunization measures.

Comment: Some commenters supported the retirement of one or more of the measures listed. Others also suggested additional measures to consider for retirement including: PN–2 Pneumococcal vaccination status and PN–7 Influenza vaccination status, and the AHRQ Abdominal Aortic Aneurysm (AAA) Mortality Rate (with or without volume) (IQI 11).

Response: We appreciate the commenters' specific suggestions regarding retirement of particular measures. As discussed in section IV.A.3.d. of this final rule, we are retiring PN–2 and PN–7 for the FY 2014 payment determination because we are adopting the global immunization measures.

Comment: A commenter pointed out that three of the measures listed (AM1–1, AMI–5, and SCIP–INF–2) for the FY 2011 payment determination overlap with the HITECH EHR incentive program Stage 1 meaningful use criteria and, therefore, they should be retired for burden reduction purposes. The commenter recommended that when the retirement of overlapped measures occurs in one program, they should also be retired in other programs as well.

Response: The final rule for the HITECH EHR incentive program (75 FR 44314) did not include the AMI and SCIP measures identified by the commenter. Rather, the measures that were finalized for HITECH EHR program hospital reporting are not currently included in the RHQDAPU program. As discussed previously, an important objective for the RHQDAPU program is to align the reporting of quality measures by hospitals for both the RHQDQPU and HITECH EHR programs. However, this alignment must be consistent with the data needs for the RHQDAPU program. The HITECH EHR program does not require the submission of patient level data, as is the case for the RHQDAPU program. Therefore, in order to completely align the clinical quality measure reporting if RHQDAPU measures were required in Stage 2 HITECH, changes to HITECH requirements would need to be made through the rule making process and also standardize other processes such as technology platform standards and submission processes. In aligning the HITECH EHR and RHQDAPU program measures, we anticipate developing electronic specifications for all of the currently chart abstracted measures. This could provide an EHR reporting alternative for measures that are currently chart abstracted. However, in developing alternative data submission mechanisms, we will be mindful of the specific uses of data submitted for RHQDAPU measures, that go beyond uses for clinical quality measures under the HITECH EHR program. Specifically, section 1886(b)(3)(B)(viii)(VII) of the Act, unlike the HITECH provisions, requires the public reporting of information regarding measures submitted to the RHQDAPU program, and the Affordable Care Act requires that measures for the HVBP program be specified under the RHQDAPU program. In view of the specific uses for RHQDAPU data, we must be satisfied that the measures results are equivalent, whether the data upon which the results are based are submitted based on chart abstraction or through use of certified EHR technology.

Comment: One commenter stated that, although the mortality measures exclude patients who have a history of Medicare hospice enrollment prior to or on admission, the measures do not take into account decisions made by the patient or family to withhold treatments and opt for comfort care later in the hospital course as part of end-of-life care. The commenter was concerned that hospitals would transfer these patients or over-treat patients to avoid penalty. The commenter suggested that CMS develop a mechanism, such as the POA flag, to accurately and properly report the care that they deliver to the patient.

Response: We thank the commenter for the input. However, we do not use rulemaking to define the parameters of the measures, such as exclusions. Rather, we depend on the processes of measure development and, if applicable, the NQF endorsement review. In the case of this measure, the exclusions in the measure were considered in the original endorsement process and at a subsequent maintenance process conducted by NQF. During the maintenance process, the measure was only modified to exclude cases where the patient had been a prior hospice patient.

(2) New Claims-Based Measures

We proposed 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 address important HHS priorities of Patient Safety and healthcare associated infections. They would be calculated using up to 3 years

of Medicare claims for discharges prior to January 1, 2011. These measures are discussed below.

(A) 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. As we proposed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23960 and 23961), we are retiring 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 proposed to adopt 2 additional Patient Safety Indicators developed by the AHRQ. These were: 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 indicator may not be useful for comparative reporting purposes, and in most cases have been endorsed by the National Quality Forum (NQF).[13] The specific measures that we proposed 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 both 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 invited comment on our proposal to adopt these two AHRQ Patient Safety Indicators for the FY 2012 payment determination.

Comment: Some commenters believed that claims data are not an accurate source of quality measures compared to medically-abstracted data. One commenter was concerned about the limitation of the claim-based measures used in *Hospital Compare* because the claims used were for the Medicare fee-for-service population only.

Response: We believe that claims data/administrative data are an appropriate data source upon which quality measures selected by the Secretary may be based. We note that many NQF-endorsed evidence-based quality measures which have been found appropriate for public reporting and quality improvement rely upon claims and administrative data as data sources. Furthermore, the use of claims-based measures reduces reliance upon chart abstraction and its associated burden for quality measurement. We acknowledge that all-payer claims/administrative data would further enhance the claims-based measures shown on *Hospital Compare*. We plan to continue to explore mechanisms to collect all-payer claims/administrative data.

Comment: Many commenters did not support the proposed inclusion of PSI–11 and PSI–12 measures because they have time-limited NQF-endorsement due to validation issues, and the delay in the AHRQ update hampers hospitals' ability to monitor the PSI results timely. The commenters believed the PSI–11 and PSI–12 measures need more refinement and testing before they can be used for public reporting. One commenter asked CMS to ensure that the PSI–12 measure is not reported twice as it is also currently reported as part of PSI–90. Some commenters felt that PSI–12 may be redundant with the SCIP VTE measure and the VTE measurement set listed under the future measure section.

Response: NQF designates some measures as having a 2-year "time-limited" endorsement when additional information like testing results are needed. All other NQF-endorsed measures have a 3-year endorsement period. However, in both instances, the measures have a status of endorsed by NQF, and undergo re-evaluation at the end of the endorsement period. Therefore, we do not agree with the suggestion to treat endorsed measures with time limitations as not endorsed. We also note that PSI–11 is endorsed without time limitation. Further, both measures are recommended for public reporting by AHRQ. We also do not agree that PSI–12 is duplicative of SCIP VTE. The PSI–12 measure reflects the actual occurrence of DVT (outcome) following a broad set of procedures. The SCIP VTE and VTE measurement set covers processes of care intended to prevent DVT.

We have carefully considered all comments received and we are finalizing the PSI–11 and PSI–12 measures for the FY 2012 payment determination. These measures are NQF-endorsed and address adverse surgical outcomes, a high HHS priority and a topic area that is currently not represented in the RHQDAPU measurement set. We will calculate these measures using the same process used for other measures based on Medicare fee for service claims.

(B) 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 final rule for additional discussion and our 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

[13] *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf.*

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/RY 2010 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 proposed to adopt as RHQDAPU measures for the FY 2012 payment determination 8 (of 10) current HACs defined in section II.F. of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23966), 6 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 UTI
- Manifestations of Poor Glycemic Control

We did not believe that it was 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 proposed 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 on Medicare beneficiaries.

We proposed 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23880) 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 updates for these eight HAC categories in this final rule. We proposed 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 this FY 2011 IPPS/LTCH PPS final rule to 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 IV.A.5.b.(6) of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23990). We invited comment on our proposal to adopt these eight HAC measures for the FY 2012 payment determination.

Comment: Some commenters supported inclusion of the HACs as measures for the RHQDAPU program as public reporting would encourage improvement. Other commenters supported inclusion, but also stressed that appropriate risk adjustment, comprehensive exclusion criteria, and NQF endorsement should be pursued.

Response: We agree that public reporting of the HACs on the *Hospital Compare* Web site would encourage improvement. We also note that section 3008 of the Affordable Care Act contains a provision for the reporting of HACs on the *Hospital Compare* Web site as well. We intend to publish measure specifications for the rates (including numerators, denominators, and exclusion criteria) in the Specifications Manual. We agree risk-adjustment may be appropriate for some of the indicators, and intend to apply appropriate risk adjustment for those HACs that are not considered Never Events, and are considered outcome measures, such as infection-related HACs. We will also consider the suggestion that we pursue NQF endorsement.

Comment: Many commenters opposed the inclusion of HACs in the RHQDAPU program for various reasons. Some commenters did not believe the HACs as currently defined by ICD–9–CM codes constitute measures as there are no measure specifications. Commenters believed that they are tied to variables which are indications of documentation and coding and may inadvertently cause unintended consequences. Other commenters also believed that present on admission (POA) reporting is in its infancy and since the HACs would rely upon POA coding, they are not reliable. Other commenters indicated that some of the HACs are too rare to be meaningful. Other commenters believed that NQF endorsement or HQA adoption would be necessary prior to adoption of the HACs.

Response: As stated in the response to the previous comment, we intend to include measure specifications in the Specifications Manual. We also believe that the HACs reflect consensus among affected parties because they were refined during two public listening sessions and underwent public comment through rulemaking. Furthermore, six of the eight HACs proposed as measures for the FY 2012 payment determination are also NQF-endorsed "never events." We acknowledge that the rates of never events may be rare. However, because these are considered events that should never happen, reporting their prevalence, though rare, is still meaningful. Although POA coding is relatively new, it is subject to the same level of monitoring and oversight as diagnoses and procedures reported on claims, and therefore, is accurate and reliable to the best of hospitals' abilities.

Comment: One commenter asked CMS to address perceived overlap in the proposed HAC measures, the proposed HAI measures, and the nursing sensitive measure set.

Response: While two of the HACs topically address HAIs, they are not the same measures as the HAIs proposed for collection via NHSN. They have a close relationship but they are not identical. In our FY 2011 IPPS/LTCH PPS proposed rule, we proposed the addition of the CDC central line catheter associated bloodstream infection rate for ICU and high-risk nursery patients and Surgical Site Infection Rate measure for inclusion in the RHQDAPU program (75

FR 23970 and 23971). These measures align with the topic areas of the Vascular Catheter-Associated Infection and Surgical Site Infection HACs. The information for determining the HACs is derived from claims data, while the central line catheter associated bloodstream infection rate for ICU and high-risk nursery patients and SSI measures are derived from chart abstraction. The central line catheter associated bloodstream infection rate for ICU and high-risk nursery patients measure (NQF #0139) is part of the NQF Nursing Sensitive Set. Section 1886(d)(4)(iv) of the Act requires the Secretary to select at least two conditions as HACs that are: (a) High cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. The Hospital Acquired Conditions are based on NQF's Serious Reportable Events.

After careful consideration of comments received, we are finalizing the adoption of the eight HAC measures into the RHQDAPU program for the FY 2012 payment determination. We will calculate these rates using Medicare Part A fee for service claims, and we intend to publicly report these measures on *Hospital Compare* starting in the fall of 2010 after an appropriate preview period. The data to be used for this initial calculation will include claims from Q4 2008, and at least Q1 and Q2 of 2009. We also note that section 3008 of the Affordable Care Act contains a provision for public reporting of the HACs on *Hospital Compare* and that initiation of public reporting of the HACs now will enable us to better fulfill the requirements of this section in the future. Since the RHQDAPU program requires hospitals to submit data for measures, hospitals have an obligation to accurately report the diagnosis and events defined for the HACs, including POA codes, on their claims, because their claims will be the source of data for these measures under the RHQDAPU program.

(3) All-Patient Volume Data for Selected MS–DRGs

We currently display 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 proposed that hospitals begin submitting as data on measures selected for the RHQDAPU program the all-patient data elements discussed in section IV.A.5.b.(5) of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23990) for 55 MS–DRGs displayed on *Hospital Compare* that relate to adopted RHQDAPU program measures (75 FR 23967). The specific MS–DRGs were listed in the proposed rule (75 FR 23970). 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 invited comments on this proposal. We also invited comments 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.

Comment: Many commenters opposed the collection of all-patient volume data in the RHQDAPU program as proposed, and stated that: (1) Volume does not constitute a quality measure and, therefore, would not fall under the Secretary's authority under the Act to select measures for the RHQDAPU program; (2) submitting all-patient volume would require the transmission of Protected Health Information or Patient Identifiable Information that is not related to either quality or reimbursement and therefore is not in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (3) it is not clear how the collection of all-patient volume data would be helpful to Medicare beneficiaries; (4) there are concerns about whether CMS infrastructure can handle data collection of a large amount of additional data; and (5) there are concerns regarding how the data will be displayed on *Hospital Compare* and fear that CMS and the public will equate high volume with high quality.

Response: We disagree with the commenters about our authority to collect all-patient volume data in relation to RHQDAPU quality measures. However, based on the public comment received, we are not finalizing this proposal because commenters indicated that, as proposed, the reporting requirement would be overly burdensome for hospitals. We plan to explore how all-patient volume may be collected in an efficient manner and reintroduce the proposal in a subsequent rulemaking.

Comment: Some commenters argued that CMS has underestimated the potential burden on hospitals which have to group the cases into one of the 55 MS–DRGs before sending the ICD–9 codes and other related data such as procedure date, discharge status, admission date, to name a few. A commenter asked CMS to provide a MS–DRG to ICD–9–CM codes equivalent table to ensure no overlapping as well as specifics on the data submission process. Another commenter suggested CMS provide an alternate method which allows hospitals already grouping data internally into MS–DRGs to post the all-patient volumes for these 55 MS–DRGs onto QualityNet on an annual basis. A commenter recommended CMS explore the possibility of getting the all-payer information from the Joint Commission's vendors, State healthcare organizations or AHRQ.

Response: We agree with the commenters that submission of the required data that would be necessary to determine the MS–DRG would be burdensome. Further, we believe that the alternative of requiring volume based on diagnosis codes would provide substantially equivalent information, even though we could not relate the volume data to a specific MS–DRG. As a result, we are not adopting our proposal to require the submission of all-payer volume in this final rule. We expect to refine the requirements for all-patient volume data submission based

on diagnosis codes and reintroduce the proposal in a subsequent rulemaking.

Comment: Some commenters supported the inclusion of all-patient volume data for selected MS–DRGs and considered the inclusion of these data a move in the right direction.

Response: We appreciate the supportive comments. As discussed previously, we expect to reintroduce the proposal in a subsequent rulemaking.

Comment: Many commenters asked CMS to provide more details about the all-patient volume data submission process. Specifically, the commenters inquired if ICD–9–CM codes have to be submitted; what data elements have to be submitted; the data formats and transmission methods; frequency of data submissions; and deadlines for data submission.

Response: We expect to reintroduce the proposal in a subsequent rulemaking as discussed previously and we would provide more details for the data submission process at that time.

After consideration of the public comments we received, we are not finalizing this proposal to collect all-patient volume data for selected MS–DRGs. We currently require hospitals to submit all-patient counts to assess the adequacy of sampling for the current RHQDAPU measures, and will examine whether this requirement can be expanded upon in the future for public reporting, and to accommodate future quality measures adopted into the RHQDAPU program.

In summary, for the FY 2012 payment determination, we are retaining 45 measures adopted for the FY 2011 payment determination, and adding 10 claims-based measures (2 AHRQ surgical outcome measures, and 8 HAC measures) for a total of 55 measures.

The RHQDAPU measure set for the FY 2012 payment determination is listed below:

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Topic	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
	• 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

Topic	RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
	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
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 for FY 2012 payment determination

BILLING CODE 4120–01–C

c. RHQDAPU Program Quality Measures for the FY 2013 Payment Determination

(1) Retention of FY 2012 Payment Determination Measures for the FY 2013 Payment Determination

We generally propose to retain RHQDAPU program measures from 1 year to the next. Consistent with this approach, we proposed to retain all of the proposed measures for the FY 2012 RHQDAPU payment determination, if finalized, for the FY 2013 payment determination. We invited public comment on the proposal to retain the 55 FY 2012 measures for the FY 2013 payment determination.

We did not receive any public comments for this section. We are finalizing the retention of the 55 FY 2012 measures for the FY 2013 payment determination. We believe that all of the 55 finalized FY 2012 measures meet the requirements for RHQDAPU program measure selection for FY 2013 and subsequent payment determinations under sections 1886(b)(3)(B)(viii)(VIII) and (IX) of the Act. As discussed previously, section 1886(b)(3)(B)(viii)(VIII) of the Act requires the Secretary to provide for such risk adjustment as the Secretary determines appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions with respect to quality measures for outcomes of care effective for payments beginning with FY 2013. Section 1886(b)(3)(B)(viii)(IX) of the Act requires, for payments beginning with FY 2013, each measure specified by the Secretary to be endorsed by a consensus entity, currently NQF, except in certain circumstances. Specifically, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus entity, the Secretary may specify a measure that is not endorsed by the consensus entity if due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

The process of care measures for AMI, HF, PN, and SCIP, the three structural measures regarding participation in a registry, and the HCAHPS patient experience of care survey being retained for the FY 2013 payment determination are all NQF-endorsed. The outcome measures being retained for the FY 2013 payment determination include the 30-day mortality and 30-day readmission measures for AMI, HF, and PN as well as the AHRQ PSIs and IQIs, the two AHRQ composite measures, and the Death among surgical inpatients for serious treatable complications measure that is both part of the AHRQ PSI measure set, and the Nursing Sensitive measure set. These measures are all NQF-endorsed and provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

The eight HAC measures adopted for the FY 2012 payment determination that are being retained for the FY 2013 payment determination represent a specified area or medical topic determined appropriate by the Secretary (CDC, CMS, AHRQ) for which a feasible and practical measure has not been endorsed by the consensus entity, and due consideration was given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. In fact, six of the HACs are NQF Never Events. The remaining two HACs are claims-based measures of HAIs, and consideration was given to chart abstracted NQF endorsed measures prior to determining that they would not be feasible to implement for the FY 2012 payment determination.

(2) New Chart-Abstracted Measure for the FY 2013 Payment Determination

We proposed to add one new chart-abstracted measure for the FY 2013 payment determination—AMI-Statin prescribed at Discharge. This measure is NQF-endorsed (NQF # 0639), and 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 was asked to review whether it should broaden the current endorsed measure specification to include the AMI population. 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.* In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23970), we stated that we would 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 the RHQDAPU program, 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 measure AMI-Statin Prescribed at Discharge beginning with January 1, 2011 discharges for the RHQDAPU 2013 payment determination.

Comment: The majority of the commenters supported the proposed addition of the AMI-Statin Prescribed at Discharge measure. Some commenters supported the addition of Statins at Discharge for AMI patients contingent on NQF endorsement.

Response: We thank the commenters for their support of this proposed measure. We note that this measure was fully endorsed by the NQF on June 11, 2010, thus meeting the requirement under section 1886(b)(3)(B)(viii)(IX) of the Act.

After consideration of the public comments, we are finalizing the measure for Statins Prescribed at Discharge for AMI patients for the FY 2013 payment determination.

(3) New Healthcare Associated Infection (HAI) Measures for the FY 2013 Payment Determination

HHS has placed high priority on reducing Healthcare Associated Infections and adopted an action plan in January of 2009. The HHS action plan identified seven HAI measures and measure targets. One of these measures, SSI–2 (as identified in the HHS Action Plan), is currently included in the RHQDAPU program (identified as SCIP–1). 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 on 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 us to consider others as well (74 FR 43876). For the measure set to be used for the FY 2013 payment determination, we proposed adopting two new HAI measures that are currently being collected by CDC via the National Healthcare Safety Network (NHSN). These measures are: (1) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139) and (2) Surgical Site Infection (SSI) (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. NHSN data collection occurs via a Web-based tool hosted by the CDC provided free of charge to hospitals. Additionally, the ability of CDC to receive NHSN measures data from EHRs may be possible in the near future. Currently, 21 States require hospitals to report HAIs using NHSN, and the CDC supports more than 2000 hospitals that are using NHSN.[14]

Both the Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure are NQF-endorsed, and therefore meet the statutory requirement under section 1886(b)(3)(B)(viii)(IX) of the Act. 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. The CDC estimates that as many as 2 million infections are acquired each year in hospitals and result in approximately 90,000 deaths per year.[15] 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. We solicited comment on the inclusion of quality measures that assess performance on HAIs as a high priority topic. We also solicited public comment on additional measures that could be added to those proposed in the FY 2011 IPPS/LTCH PPS proposed rule for public reporting and quality improvement.

Comment: Many commenters supported the proposed use of the CDC/NHSN to collect HAI measures. However, some commenters stated that the NHSN data input process is burdensome and commenters questioned the CDC/NHSN's readiness to handle the new enrollment of one fourth of the RHQDAPU participating hospitals. Many commenters recommended that CMS collaborate with the CDC to streamline and synchronize the data collection mechanism and measure specifications prior to implementation, and to limit the surgical procedures for inclusion in data reporting. Commenters recommended development of robust training and technical support for NHSN collection. Many commenters supported phasing in these measures in order to allow hospitals to adjust to the reporting requirement, adopting one measure for collection in FY 2011 and another for collection in FY 2012.

Response: We thank the commenters for their support and suggestions. Concurrently with the development of the FY 2011 IPPS/LTCH PPS final rule, we have been in extensive discussions with the CDC regarding the development and enhancements to the existing NHSN and CMS infrastructure that would enable utilization of the NHSN to report one or more measures to CMS. These enhancements include improved user support and training materials as well as streamlined specifications for collection of required data needed to calculate the HAI measures adopted for RHQDAPU. In the future, we will also be working toward the ability to receive reports electronically from hospital EHRs. We agree that phasing in these measures will allow more time for hospitals to adjust to the reporting requirements of the NHSN and, as discussed below, are finalizing the CLABSI measure for the FY 2013 payment determination and the SSI measure for the FY 2014 payment determination. We intend to limit the data elements required for RHQDAPU reporting to the subset of data elements, populations and procedures needed to calculate the NQF-endorsed measures we have proposed.

Comment: A few commenters asked CMS to clarify how the proposed HAI measures reported via NHSN would be validated and publicly reported. Specifically, the commenters requested clarification whether the data will be stratified by type of hospitals in *Hospital Compare.*

Response: We are considering adding CDC/NHSN measures to our validation process, as outlined in section IV.A.7.b. of this final rule. We acknowledge the need for uniformity in the data that will be publicly reported and used in the HVBP program. We will examine the need to validate these data, and may propose validation requirements for these data in the future, should we determine a need. We plan to publicly report the data for HAI measures collected through the NHSN on the *Hospital Compare* Web site as we do for other RHQDAPU program measures. Currently, the NQF specification stratifies the measure by type of unit within a hospital. We note NQF-endorsed measure specifications for measures adopted into the RHQDAPU program are subject to periodic revision, and such revisions will also be reflected in what we require hospitals to submit to the RHQDAPU program.

Comment: Some commenters were concerned that publishing administrative data via the HAC list, hospitals reporting to NHSN, and collecting data in another format could cause confusion for stakeholders.

Response: We will take steps to determine how best to display these data so that they do not cause confusion for viewers.

(A) Central Line Associated Blood Stream Infection (CLABSI)

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.

[14] *http://www.cdc.gov/nhsn/.*

[15] 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.

(B) Surgical Site Infection (SSI)

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 adopted by the HQA in 2008).

We invited 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 proposed 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 IV.A.5.b.(6) of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23990).

Comment: A few commenters supported the inclusion of CLABSI for the FY 2013 annual payment determination, stating that CLABSI is the only measure that can be adopted quickly to meet the statutory requirement for inclusion in the HVBP program without undue burden on hospitals. Some commenters indicated that a phased in approach starting with the inclusion of the CLABSI measure is appropriate. The commenters provided several suggestions to implement the CLABSI: (1) Provide clarification whether the CLABSI data collection is unit-based or hospital-based; (2) provide clarification whether any or all surgical procedures apply to specific populations like adult, pediatric or both; (3) limit the number of surgeries reported for the 1st year; and (4) States with existing HAI reporting mandates be deemed to meet the CMS reporting requirements by meeting their State mandate.

Response: We agree that because more hospitals are submitting the CLABSI measure, this measure would be the most feasible of the two proposed measures for hospitals to implement quickly, and that a phased in approach to adopting the HAI measures is warranted. The CLABSI measure is the one that is most commonly required by States, and currently most commonly reported among the HAI measures collected through the NHSN system. The CLABSI measure is currently stratified by type of ICU unit within the hospital, but is aggregated to the hospital-level by the NHSN. For the RHQDAPU program, we would limit the required data elements, populations and procedures to only those needed to calculate the NQF-endorsed measure. For the NQF-endorsed measure, the procedures that apply are: Coronary artery bypass graft and other cardiac surgery, hip or knee arthroplasty, colon surgery, hysterectomy (abdominal and vaginal), and vascular surgery, and the populations that apply are both the adult and pediatric populations. These procedures also correspond to the procedure categories used in SCIP. Capturing SCIP process-of-care data and NHSN SSI data for the same procedure categories will provide process and outcome data for the same patient populations. Regarding the extent that a State requirement can be used to satisfy the RHQDAPU program requirement, if the data submission requirement overlaps 100 percent with the requirements for the RHQDAPU program, it will be possible to satisfy both requirements with one submission. However, a State may mandate additional requirements beyond what is required for RHQDAPU, for example States may also be requiring the release of information to the State for public reporting at the State level, which would of course be in addition to the RHQDAPU requirement for public reporting. If a State mandate requires fewer data elements than what is required for RHQDAPU, hospitals participating in RHQDAPU will be required to submit the additional data in order to satisfy the RHQDAPU requirement.

Comment: Many commenters did not support the SSI measure for FY 2013, citing resource constraints, a lack of clarification in data collection procedure, the absence of risk-adjustment for data presentation in *Hospital Compare;* and a lack of clarification in exemptions for small hospitals.

Response: We are finalizing only one HAI measure for the FY 2013 payment determination, the CLABSI measure, in order to allow hospitals to gain more experience with these types of measures and the new collection mechanism. We are finalizing the SSI measure for the FY 2014 payment determination. In our view, both measures are equally important. However, we believe this approach of phasing in the measures will minimize the additional reporting burden on hospitals that are in States that do not currently mandate reporting of infection data to the NHSN, and will also allow time to address any measurement issues, such as those raised by commenters, for the SSI measure.

Comment: One commenter strongly urged CMS to incorporate all seven HAI metrics from the DHHS Action Plan into the RHQDAPU program to ensure the corresponding HVBP program HAI topic is developed and included in performance scoring by FY 2013. Another commenter suggested CMS address the execution of the HVBP program with respect to the targeted outcome metrics from HAIs as required by the Affordable Care Act.

Response: We thank the commenters for their recommendations and will consider them in future rulemaking. This FY 2011 IPPS/LTCH PPS final rule does not directly address the HVBP program authorized by section 3001 of the Affordable Care Act. We refer readers to section IV.A.14. of this final rule where we discuss the relationship between the RHQDAPU and HVBP programs.

After consideration of the public comments we received, we are finalizing the CLABSI measure for the FY 2013 payment determination. Collection for the CLABSI measure will begin with January 1, 2011 discharges. Also, based upon public comment, we are finalizing the SSI measure for the FY 2014 payment determination with collection to begin with January 1, 2012 discharges. We expect the CLABSI measure and the SSI measure to be risk-adjusted consistent with section 1886(b)(3)(B)(viii)(VIII) of the Act for the FY 2013 and FY 2014 payment determinations, respectively.

(4) New Registry-Based Measures

For the FY 2013 payment determination, we proposed 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 proposed 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 proposed 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 IV.A.13. of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23997), we specified the self-nomination process we proposed to use to qualify registries for each proposed registry-based measure topic. Proposed submission requirements for the proposed registry-based measures were discussed in section IV.A.5.b.(7) of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23990 through 23991).

Comment: Some commenters stated that the use of registries has the potential for inconsistent reporting on *Hospital Compare* and inaccurate comparisons across hospitals. Hospitals may cherry-pick the measures they do best on and yet the measures may not fully reflect the care they provide. One commenter stated that if registries are used, hospitals should be required to report to more than one registry so that they cannot just pick the registry in which they have the best data.

Response: After consideration of the public comments received, we are persuaded that we should not finalize any registry-based measures at this time.

As noted above, after consideration of public comments received, we are not finalizing any registry-based measures at this time.

Below is a discussion of the four proposed registry-based measure topics and specific registry-based measures that fall within each topic that we proposed to add to the RHQDAPU program for the FY 2013 payment determination.

(A) 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.[16] 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, [17] which in turn increases its cost, the patient's length of stay, and the patient's risk of mortality.[18] 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 implantable cardioverter defibrillator (ICD) complications. This measure is a risk standardized 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 under Phase 1 of a call for Patient Outcome Measures initiated in fall of 2009. We proposed 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 anticipated a final endorsement decision in the fall of 2010 after publication of this FY 2011 IPPS/LTCH PPS final rule.

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 CMS 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, CMS requires that hospitals submit data to the ACC–NCDR ICD registry for primary prevention patients only and does 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 proposed that hospitals also submit to the qualified ICD complications registry 11 additional data elements not currently required under the NCD in order for the measure to be calculated for RHQDAPU program purposes.

In summary, we proposed 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 proposed 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 proposed to qualify one registry for this topic. Proposed registry qualification criteria were discussed in section IV.A.13. of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23997). 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

[16] 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.

[17] Hammill S and Curtis J. Publicly Reporting Implantable Cardioverter Defibrillator Outcomes—Grading the Report Card. *Circ Arrhythmia Electrophysiol.* 2008;1:235–237).

[18] Al-Khatib SM, Greiner MA, Peterson ED, Hernandez AF, Schulman KA, Curtis LH. Patient and Implanting Physician Factors Associated With Mortality and Complications [9]After Implantable Cardioverter-Defibrillator Implantation, 2002–2005. *Circ Arrhythmia Electrophysiol.* 2008;1:240–249.

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 topic.

Comment: Several commenters supported the inclusion of the ICD complications measure. One commenter was concerned with the quality of data collected by the ACC–NCDR ICD Registry and the STS Cardiac Surgery Registry, specifically related to data definition ambiguity and varying levels of expertise amongst abstractors across hospitals. One commenter pointed out the problem of lack of standardization of data and measure quality and data submission process across registries. One commenter suggested that CMS provide information on the impact of the ICD measure on hospital's management of cardiac patients.

Response: As stated previously, we have decided not to finalize any registry-based measures at this time. We understand the commenters' concerns and will consider them in future rulemaking.

Comment: One commenter suggested that CMS provide detailed data definitions to guide hospital coders to code complications in order to avoid over or under documentation of complications by physicians.

Response: As stated previously, we have decided not to finalize any registry-based measures at this time. We will take this into consideration for future rulemaking.

As stated previously, we are not finalizing any registry-based measures in this final rule.

(B) Stroke Registry-Based Topic and Measures

We previously 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 have 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 proposed to include the following eight measures in the Stroke registry-based topic:

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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.
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.

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We proposed to add the stroke registry-based topic, which would include these eight registry-based stroke measures, to the RHQDAPU 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 invited comment on the measures as well as the timing of their addition to the RHQDAPU measure set.

Comment: Several commenters supported the stroke measures, and suggested the measures be accepted by conventional chart abstraction, EHRs or registry submission.

Response: As stated previously, we have decided not to finalize any registry-based measures at this time. We thank the commenters for their support and suggestions and will take them into consideration in future rulemaking.

Comment: Some commenters did not support the Stroke registry-based topic until the measure specifications are harmonized with the Get with the Guidelines stroke registry, the NHIQM Stroke specifications, and meaningful use requirements. A commenter recommended delaying the implementation of any stroke measure set until they can be obtained electronically. Another commenter requested CMS to allow the Joint Commission-accredited organizations to use ORYX® stroke measure data as a means for and in lieu of participating in a registry. One commenter asked that CMS add an exclusion to the Stroke thrombolytic therapy measure for patients who do not have an ER/admitting diagnosis of stroke.

Response: We thank the commenters for their support and suggestions. Because we are not finalizing registry-based measures at this time, we will consider these suggestions in future rulemaking. We intend to propose the Stroke measurement set for inclusion in a future payment determination.

As stated previously, we are not finalizing any registry-based measures in this final rule.

(C) 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 proposed 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 invited comment on the proposed addition of a nursing sensitive care registry-based topic, which would include eight 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)

Comment: Many commenters supported the nursing sensitive care measures/measure set, but objected to registry-based submission of the measures for various reasons.

Response: We thank the commenters for their support of the proposed measures. We will not be finalizing any of the registry-based measures in this final rule.

Comment: One commenter did not support the inclusion of the eight Nursing Sensitive measures proposed earlier unless significant restructuring of the specifications were conducted and these specifications were made available to the public. Another commenter supported the proposed addition of Nursing Sensitive Care HAC measure and topic.

Response: As stated earlier, we are not finalizing any of the registry-based measures in this final rule. We thank the commenters for their support and suggestions. We will consider these suggestions in future rulemaking.

As stated earlier, we are not finalizing any of the registry-based measures in this final rule.

(D) 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, which means that if they choose this registry-based topic for purposes of the FY 2013 payment determination and the registry to which they already submit data is qualified for this proposed topic, they will not face any additional data submission burden.

For the FY 2013 payment determination, we proposed 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. We did not propose to retire the structural measure for cardiac surgery participation.

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

These measures were endorsed by the NQF in May of 2007 and meet the statutory requirement of reflecting consensus among affected parties. We proposed that 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, which requires that the data needed to calculate these measures 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 invited public comment on this proposal.

Comment: Many commenters supported the cardiac surgery measures/measure set, but objected to registry-based submission of the measures.

Response: We thank the commenters for their support of the proposed measures. As stated earlier, we are not finalizing any registry-based measures in this final rule.

Comment: One commenter was concerned with the quality of data collected by the STS Cardiac Surgery Registry, specifically related to data definition ambiguity and varying levels of expertise amongst abstractors across hospitals. Another commenter recommended requiring all hospitals to participate in registries to report specific measures sets, and to phase in the measures sets starting with cardiac surgery and nursing sensitive measures.

Response: We agree with the importance of cardiac surgery measures that include both processes of care and outcomes in view of the significance of such surgery and the benefit of having such measures publicly reported. Although we have decided not to adopt registry-based reporting in this final rule, we continue to believe that cardiac surgery measures are a priority for the RHQDAPU program.

Comment: Some commenters stated that the use of registries has the potential for inconsistent reporting on *Hospital Compare* and inaccurate comparisons across hospitals. Hospitals may select to participate in registries for measures that they expect the best performance. Thus, allowing hospitals to report on only one registry-based measures set may not fully reflect the care the hospital provides. One commenter stated that if registries are used, hospitals should be required to report to more than one registry so that they cannot just pick the registry in which they have the best data.

Response: We continue to believe that registry participation is very beneficial, providing ongoing measurement of quality of care, feedback to participants, and the ability to measure outcomes. We intend to continue considering how best to implement registry reporting as a means for data submission. In doing so, we will consider allowing registry-based reporting as an option, rather than a requirement, and to address the issues of data comparability. We agree that if the option to report measures by a registry is adopted, is important to assure that measures specifications are standardized.

After consideration of public comments received, we will not finalize any registry-based measures at this time.

In summary, based on the public comments received, for the FY 2013 payment determination, we are retaining the 55 measures adopted for the FY 2012 payment determination, and are adding 1 chart abstracted measure (AMI–Statin at Discharge) and 1 HAI measure to be collected via NHSN (Catheter Associated Bloodstream Infection) for the FY 2013 payment determination. Collection of these two new measures for the FY 2013 payment determination will begin with January 1, 2011 discharges. We refer readers to section IV.A.5. of this final rule for further information about submission requirements. We are not finalizing our proposal for hospitals to pick one of four topics in which to initiate registry-based measure submission to a qualified registry. As discussed in section IV.A.13., we also are not finalizing our proposal to qualify registries for these four topics. In the future, we anticipate offering registry-based submission as a mechanism to submit data for

RHQDAPU measures, but not necessarily the sole mechanism to submit data for RHQDAPU measures.

Set out below are the 57 RHQDAPU program quality measures to be used for the FY 2013 payment determination:

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Topic	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
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients

Topic	RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS 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**
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 Infections*
	• Catheter-Associated Urinary Tract Infection (UTI)*
	• Manifestations of Poor Glycemic Control*

* New for FY 2012 payment determination.
** New for FY 2013 payment determination.

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d. RHQDAPU Program Quality Measures for the FY 2014 Payment Determination

(1) Retention of FY 2013 Payment Determination Measures for the FY 2014 Payment Determination

We proposed 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 invited public comment on this proposal. We did not receive any specific comments on this proposal. As discussed below, in response to comments, we are retiring 2 FY 2013 narrowly specified measures (PN–2 and PN–7) and adopting in their place 2 global immunization measures. We are adopting as final our proposal to retain all of the measures adopted for the FY 2013 payment determination for the FY 2014 payment determination, as modified by our retirement of these FY 2013 measures.

(2) New Chart-Abstracted Measures for the FY 2014 Payment Determination

We also proposed to add the following four new chart-abstracted measures to the RHQDAPU program measure set for the FY 2014 payment determination: (1) Emergency Department (ED) 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 recognized that we were proposing to increase the chart-abstraction burden on hospitals with respect to the RHQDAPU program. However, we stated that 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 IV.A.2.b.(1) of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23965). 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. We proposed to adopt these four chart-abstracted measures into the RHQDAPU program measure set for the FY 2014 payment determination. We proposed that data submission for these measures would begin with January 1, 2012 discharges. We invited comment on these proposed measures as well as on the proposed timing of their addition to the RHQDAPU program for the FY 2014 payment determination.

(A) Emergency Department (ED) Throughput Measures

The two ED Throughput measures we proposed for the FY 2014 payment determination were: (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); thereby, meeting the requirement of section 1886(b)(3)(B)(viii)(IX) of the Act. They also have been adopted by HQA. Specifications for these measures are available in the preview section of the current Specification 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.

Comment: Many commenters supported the inclusion of the proposed ED Throughput—Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497), and ED Throughput—Median time from emergency department arrival to ED departure for admitted patients (NQF #0495) measures. Some commenters supporting these measures agreed that the measures should reflect not only processes within the emergency department but also reflect coordination of care, communication and efficiency of provision beyond the walls of the emergency department. However, some of the commenters believed that the measures need to be refined, terminology needs to be clearly defined, and a percentile should be used to identify outliers. Some commenters stated that implementation of the ED measures should be contingent upon successful EHR testing by CMS so the measures can be reported electronically and not via manual chart abstraction. Several commenters opposed the proposed ED Throughput measures, stating there are multiple factors affecting the ED admit decision time to ED departure time for admitted patients as well as the median time from ED arrival to ED departure for admitted patients and the proposed measures cannot be adequately interpreted to evaluate quality. Commenters requested that CMS take into consideration timing factors that are outside the control of the ED, for example, bed availability and patient characteristics.

Response: We appreciate the supportive comments as to the importance of the ED throughput measures. Specifications are handled through a sub-regulatory process previously described with specifications updated as needed. In order to gain experience prior to the date of required RHQDAPU submission, we encourage hospitals to take advantage of the voluntary submission process, which we plan to have available starting in October 2010. Although we believe that the measures are well specified, experience gained through the voluntary reporting mechanism will assist us to identify any needed refinements, prior to the beginning of required submission for the RHQDAPU program to begin with January 1, 2012 discharges. We will consider the suggestion regarding showing the percentile distribution to allow consumers to discern outliers when publicly reporting the measures. With regard to electronic submission, we are working to provide an optional mechanism for electronic submission for ED and other RHQDAPU chart-abstracted measures.

After consideration of the public comments received, we are finalizing the two ED–Throughput measures as

proposed for the FY 2014 payment determination.

(B) Global Immunization Measures

For the FY 2014 payment determination, we proposed 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 deaths related to flu. Vaccinations can significantly reduce the number of flu related illnesses and deaths. The measures being proposed are currently endorsed by the NQF, which occurred 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 in an upcoming release of the Specifications Manual to be published in October 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.

Comment: Some commenters strongly supported the proposed addition of the Global Immunization measures ((1) Pneumoccocal Immunization; and (2) Influenza Immunization) to the RHQDAPU program. The commenters also recommended a measure threshold and exemptions, for example, in times of vaccine shortage.

Response: We thank the commenters for supporting these measures. We will take into consideration these suggestions for exemptions during vaccine shortages. We are finalizing these measures for the FY 2014 payment determination.

Comment: Some commenters expressed concerned that the proposed FY 2014 global immunization measures overlap with previously adopted immunization measures that are specific to the Pneumonia population (PN–2: Pneumoccocal Vaccination Status and PN–7: Influenza Vaccination Status). Commenters also recommended that we retire the two pneumonia-specific measures if we elect to adopt the global immunization measures into the RHQDAPU program.

Response: We agree with the commenters and are retiring the PN–2 and PN–7 measures from the RHQDAPU measure set for the FY 2014 payment determination because these measures overlap with the global immunization measures that we are adopting for the FY 2014 payment determination.

Comment: Several commenters opposed the inclusion of the Global Influenza or Global Pneumococcal measures into the RHQDAPU program because of perceived burden of collection. In addition, some commenters stated that vaccination during the acute phase of illness treated in the hospital inpatient setting is not an optimum practice, and that miscommunication with patients' primary care provider may lead to unnecessary vaccinations.

Response: We understand the burden concern and have attempted to mitigate this by adopting the ED throughput and Global immunization measures concurrently as they utilize the same global population, and adopting the measures several years in advance. We believe that finalizing the global immunization measures for FY 2014 in this final rule will give hospitals adequate time to develop efficient collection plans for future collection. We agree with the commenters that the current RHQDAPU immunizations specified for the pneumonia inpatient population should be replaced in favor of these broadly applicable immunization measures. The NQF also recommends the use of the global immunization measures over the condition specific immunization measures that are currently in the program. Based on the public comments received, we are adopting the two global immunization measures for the FY 2014 payment determination, and we are retiring the PN–2: Pneumoccocal Vaccination Status and PN–7: Influenza Vaccination Status measures for the FY 2014 payment determination in order to accommodate these more broadly applicable immunization measures.

As for the commenter's point that a patient's primary care provider would ordinarily be the locus for immunization, the current NQF-endorsed measures recognize a role for the acute care setting to assess the vaccination status of and to intervene in the appropriate vaccination of acutely hospitalized patients against influenza and pneumonia. This is consistent with the indications for these vaccines which are global in nature in the sense that they are generally recommended for patients over a certain age, not those with only who have contracted pneumonia. We will provide specifications for these new measures in the upcoming Specifications Manual release.

After consideration of the public comments received, we are finalizing all four chart-abstracted measures into the RHQDAPU program measure set for the FY 2014 payment determination. Also based upon public comments received, and discussed in section IV.A.3.c.(3) of this final rule, we are finalizing the adoption of the SSI measure to be collected via NHSN for the FY 2014 payment determination. Data submission for these five measures would begin with January 1, 2012 discharges. In addition, based on comments received regarding retirement of narrowly specified measures when broader measures are available, we are retiring the PN–2 and PN–7 measures for the FY 2014 and subsequent payment determinations, which will be replaced by the two global measures for influenza and pneumococcal vaccination beginning with January 1, 2012 discharges. We will retain the remaining FY 2013 measures for the FY 2014 payment determination. We expect the CLABSI measure and the SSI measure to be risk-adjusted consistent with section 1886(b)(3)(B)(viii)(VIII) of the Act for the FY 2013 and FY 2014 payment determinations, respectively.

The complete list of 60 quality measures to be used for the FY 2014 payment determination is set out below.

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Topic	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-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
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients

Topic	RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS 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***
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*

4. Possible New Quality Measures for Future Years

We invited public comment on the following quality measures and topics set out below that we are considering for the future. We also sought suggestions and rationales to support the adoption of measures and topics that were not included in this list for the RHQDAPU program.

Topic	RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
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 ***

*New for FY 2012 payment determination.
**New for FY 2013 payment determination.
*** New for FY 2014 payment determination.

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
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

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Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
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

• *General comments*

Comment: A commenter recommended that any long-range planning must be consistent with the Secretary's strategic plan and priorities which are unknown at this time for the future years. A commenter stated that CMS needs to have a more systematic quality measure strategy and framework to align measures in order to achieve the overall goals of quality improvement and attainment. Another commenter stated that hospitals should be allowed to prioritize measures based on risks of their populations and programs and questioned the reason why hospitals are not given the option as physicians to select from a list of measures to focus on their quality improvement efforts. The commenters suggested that we follow a more methodical framework to prioritize and integrate measures into the RHQDAPU program and the HITECH EHR incentive program with a long-term goal of transitioning from the RHQDAPU program to the meaningful use criteria under the HITECH EHR program. One commenter noted that in moving forward, CMS should focus on developing measures collected through EHRs rather than using manually intensive, chart-based measures through the RHQDAPU program. Several commenters believed that many of the proposed measures for future years overlap with the current RHQDAPU measures. Another commenter recommended that CMS focus reporting on a variety of aspects for fewer conditions rather than adding one or two measures in a particular medical condition or significantly increasing the overall number of conditions being measured at any one time. The commenter believed that the second approach would stretch hospital resources. Another commenter noted that it is unnecessary to put a single measure under different composite measures or under different reporting requirements. The commenter gave the PSI–4 measure as an example which is required in both the Nursing sensitive composite measure as well as in the AHRQ Patient Safety Indicators measurement set. A commenter suggested that CMS take a more aggressive approach and add more measures in high priority areas.

Response: We have retained the ability to modify the measure set in the future in order to respond to changes in our priorities as well as changes in legislation. One of our goals is to align the quality measures across programs including the HITECH EHR program in order to reduce the burden on hospitals reporting quality measures to multiple programs. We generally try to adopt measures for the RHQDAPU program that are broadly applicable across IPPS hospitals, because RHQDAPU measures are made publicly available in comparative reporting tools, and will be the basis for measure selection for hospital value based purchasing in the future. Allowing hospitals to pick among measure sets may not be ideal for comparative public reporting and performance-based incentive programs.

With respect to long-range planning and the Affordable Care Act required strategic plan and priorities, we agree that the RHQDAPU program priorities will be guided by this plan. Although this plan is yet to be developed, the measures that we include in this final rule represent established HHS priorities, which include some of the priorities selected by the NQF National Priorities Partners process. These include patient safety, population health, and care coordination.

The new outcomes measures, the HACs and HAIs, the immunization measures, AMI statin at discharge, and ED throughput measures finalized in this final rule reflect these priorities as we discuss in the portions of this final rule dealing with those measures. To the extent that these or other measures are incompatible with any revision to HHS priorities and new strategic framework, the measures can be modified. Because IPPS hospitals provide a broad array of services, we believe that it is important have an array of measures that cover very substantially inpatient services. We also believe it is beneficial to consumers to measure and report many topics governing aspects of health care delivered in hospital settings, and thus, we have been systematically expanding the RHQDAPU program quality measures in scope and topic. Currently, AHRQ PSI–4 is in both the AHRQ Patient Safety Indicator measure set and the Nursing Sensitive Care measure set. We have not adopted the Nursing Sensitive Measure set at this time, but would address this overlap in the future should we propose to require this measure set of participating hospitals. We will also continue to assess the feasibility of alternative data sources for measures, such as registries and EHRs to lessen the data collection burden on hospitals. We agree with the importance of transitioning to EHR submission of RHQDAPU measures and plan to actively move toward implementation. However, we expect that, at least in the short term, it would not be practical to require all hospitals to report using EHR technology, but rather to provide this reporting method as an option.

• *Comment on Measure Topic: Atrial fibrillation*

Comment: A commenter indicated that atrial fibrillation measures is the root cause of several conditions upon which CMS has focused and that quality measures for atrial fibrillation help alert hospitals and clinicians to diagnose and manage the condition.

Response: We agree and we did propose the STK–3: Anticoagulation therapy for atrial fibrillation/flutter (NQF #0436) in the FY 2011 IPPS/LTCH proposed rule under proposed measures for the Stroke registry-based topic. As discussed previously, we are not finalizing any registry-based measures in this final rule. We will take the commenter's suggestion into

consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

• *Comment on prioritization of Measure Topics*

Comment: One commenter recommended that CMS prioritize the cardiovascular-related conditions that are in the CMS top 20 based on root cause and prevention of subsequent conditions as follows: Diabetes, ischemic heart disease, atrial fibrillation, acute myocardial infarction, congestive heart failure, stroke, Alzheimer's disease, and depression.

Response: We thank the commenter for the suggestions and we will take the commenter's suggestion into consideration in determining the priorities of the measures for the RHQDAPU program in the future.

• *Comments on Measure Topic: Cardiac rehabilitation referral for AMI, HF, and Cardiac Surgery*

Comment: A few commenters strongly endorsed the proposal to consider "Cardiac Rehabilitation Referral for AMI, HF, and Cardiac Surgery" for possible RHQDAPU program futures measure and topics.

Response: We thank the commenters for their support of the proposed measure. We will take that into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

• *Comments on Measure Topic: Percutaneous coronary intervention (PCI)*

Comment: A few commenters requested the addition of percutaneous coronary intervention (PCI) in the RHQDAPU measures for future years.

Response: We thank the commenters for the suggestion and we will take it into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

• *Comment on Measure Topic: Participation in a systematic database for general thoracic surgery*

Comment: One commenter suggested the inclusion of participation in a systematic database for general thoracic surgery as a structural measure.

Response: We thank the commenter for the suggestion and we will take it into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

• *Comments on Measure Topic: 30-day AMI and heart failure care transition composites*

Comment: A few commenters urged CMS not to include composite measures for 30-day AMI and heart failure care transition composites because they believed they do not accurately identify differences in performance that are due to failure to provide adequate care coordination and may penalize providers unfairly from serving disadvantaged population served or providing unrelated emergency department visits. One commenter recommended the inclusion of more AMI measures.

Response: We acknowledge these concerns. These measures are currently undergoing NQF review and endorsement. We also thank the commenter that supported the addition of AMI measures.

• *Comment on Measure Topic: Initiation of statin therapy in patients with ischemic stroke or acute AMI prior to discharge*

Comment: One commenter recommended adding a measure for the initiation of statin therapy in patients with ischemic stroke or acute AMI prior to discharge when there is no contraindication.

Response: We thank the commenter for the suggestion and we will consider it in future rulemaking.

• *Comment on Measure Topic: Smoking cessation screening, treatment, and post-discharge follow-up*

Comment: One commenter suggested the inclusion of measures like the smoking cessation screening, treatment, and post-discharge follow-up measures which are being pilot tested by the Joint Commission.

Response: We thank the commenter for the suggestion and we will take it into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

• *Comment on Measure Topic: 30-Day PCI Readmission Measures*

Comment: One commenter supported the PCI mortality and readmission measures and urged CMS to reconsider delayed implementation of the measures after FY 2014 and consider implementing PSI–9 and/or other measures to track severe bleeding as a preventable readmission from PCI. One commenter opposed the PCI readmission measure. This commenter opposed the data quality (probability matching with CMS data), timeframe (30-day) and numerator (readmission for all-cause) of the measure and the validity of the risk adjustment model (as indicated by the low C-statistic).

Response: The PCI readmission measure was developed using a probabilistic match to link the registry data with the Medicare data but would be implemented using direct patient identifiers. As to the time frame of the measures, we selected 30-day period of assessment based on empirical analysis of available data, clinical judgment and the advice of expert consultants. The consensus was that a 30-day time provided the correct balance by capturing the bulk of excess readmissions occurring after PCI and maintaining a high likelihood that the readmission was attributable to the hospital care. Moreover from a patient perspective, readmission for any reason is likely to be an undesirable outcome of care. Readmissions not associated with a cardiac diagnosis may be directly related to the care delivered during the index hospitalization. Finally in regard to the low C-statistic, two factors affect the C-statistic—patient factors and hospital care. Since the patient-level predictors included in the risk adjustment model for the PCI measure were robust based on registry clinical data, the C-statistic of 0.663 indicates that the quality of care delivered to patients by hospitals (that are not part of the model) plays a larger role. We will consider the comment regarding adoption of other companion measures, such as PSI–9, that may address preventability.

Comment: One commenter supported the inclusion of Catheter-Associated UTI and VAP in FY 2014.

Response: We thank the commenter for the support of the proposed measure. We will take it into consideration in determining whether to adopt these measures for the RHQDAPU program in a future rulemaking cycle.

• *Comment on Measure Topic: HACs*

Comment: One commenter recommended that CMS make a long-term goal to cultivate more global hospital-wide assessments of harm rather than targeting individual organisms or HACs.

Response: We thank the commenter for the suggestion and we will take it into consideration in determining whether to adopt this kind of measure for the RHQDAPU program in the future.

• *Comments on Measure Topic: HAI*

Comment: One commenter recommended the inclusion of HAI—ventilator associated pneumonia, HAI—multidrug-resistant organism infection, and HAI—CDAD. Another commenter cautioned that for the possible inclusion of the VAP measures, the term "VAP" must be clearly defined so that trauma or immune-compromised patients can be diagnosed correctly for VAP and recommended that CMS take into consideration the inadvertent penalty of academic medical centers and hospitals that treat complex and critically-ill patients who are at risk for MDRO, and experience high volume of patient transfer.

Response: We thank the commenters for their suggestion for other HAIs and

we will take this into consideration in determining whether to adopt the measures for the RHQDAPU program in the future. We plan to propose additional HAI measures in a future rulemaking cycle as they gain NQF endorsement.

Comment: A commenter recommended that the HHS Action Plan to Prevent Healthcare-associated Infections must be assessed for whether the Plan's metrics and targets have been met and to provide the results to the public at the hospital level, especially measures related to MRSA, CDAD, and UTI. A commenter urged CMS to add the Catheter-Associated UTI in FY 2012. The commenter suggested CMS and CDC collaborate to develop a workable guideline for identifying hospital-acquired VAP infections, moving surveillance and reporting of central line associated bloodstream infections beyond the ICU. The commenter did not recommend using NQF-endorsement alone as adoption criteria. Another commenter recommended that no further data submission plan be proposed for VAP, MRSA, and CDAD until after fall of 2010 when the HHS HAI Action Plan Review and Update is released.

Response: We will take these comments into consideration for planning and measure selection. We appreciate the commenter's suggestion that we add the Catheter-Associated UTI in FY 2012, but we have determined that we will consider it for future years. The HHS Action Plan is currently undergoing a process of interdepartmental review and update that will include an examination of the metrics and targets. We anticipate that this will be complete in October 2010.

- *Comments on Measure Topic: VTE*

Comment: One commenter suggested the inclusion of a thromboembolism (VTE) measure into the RHQDAPU program for future years. One commenter requested clarification for the documentation requirements for the VTE–1 VTE Prophylaxis and for the VTE–2 ICU VTE Prophylaxis. The commenter also agreed with the exclusion of patients with reasons for not administering mechanical and pharmacological prophylaxis.

Response: We appreciate the suggestion and agree with the high importance of the VTE topic. With respect to specifications and documentation requirements these are handled through a sub-regulatory process.

- *Comment on Measure Topic: Surgical Safety*

Comment: One commenter supported the continued development of Surgical Safety measures.

Response: We thank the commenter for the encouragement and we will take that into consideration in determining whether to adopt more of these types of measures for the RHQDAPU program in the future.

- *Comment on Measure Topic: NQF-approved serious reportable events.*

Comment: One commenter suggested that CMS adopt NQF-endorsed serious reportable events in future years.

Response: We thank the commenter for the suggestion and we will take it into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

- *Comments on Measure Topic: Influenza vaccination of healthcare personnel*

Comment: Many commenters recommended the inclusion of Influenza vaccination of healthcare personnel.

Response: We agree that Influenza vaccination of healthcare personnel is an important practice that may prevent the spread of influenza and we thank the commenters for their recommendation. We will take this into consideration in determining whether to adopt this measure for the RHQDAPU program in the future.

- *Comment on Measure Topic: Mortality measures*

Comment: A commenter strongly opposed the inclusion of mortality measures because they are inconsistent and unreliable indicators of the quality of patient care. Furthermore, the commenter stated that mortality measures do not take into account terminal, end-of-life issues, or withhold treatment decisions made by patients and families.

Response: These comments were related to the prospect of inconsistent approaches to mortality measures resulting from inclusion of various registry-based measures sets. We have withdrawn the registry-based reporting proposal. We have added no additional mortality measures beyond the CMS 30-day mortality measures and the AHRQ PSI and IQI mortality measures. These measures and their underlying methodologies are all endorsed by NQF.

We thank the commenters for all their suggestions for quality measures for the future years. We also note that, although we did not adopt the proposed registry-based measures: Stroke, Cardiac Surgery, and Nurse Sensitive measures for the FY 2013 payment determination in this final rule, we are still very interested in reconsidering them for future adoption. While the stroke measures were proposed only for registry-based participation in the proposed rule, and not finalized, these measures are currently specified for chart abstraction and electronically specified for EHR submission and included in the HITECH EHR incentive program for 2011 and 2012. We intend to propose to add these measures to the RHQDAPU program in future rulemaking. In addition, while we did not propose the VTE measures set in the FY 2011 IPPS/LTCH PPS proposed rule, which are also included in the HITECH EHR incentive program for 2011 and 2012, we intend to propose to add these measures to the RHQDAPU program in future rulemaking.

5. Form, Manner, and Timing of Quality Data Submission

Sections 1886(b)(3)(B)(viii)(I) and (II) of the Act state that the payment update, for FY 2007 and each subsequent fiscal year, be reduced by 2.0 percentage points (or, beginning with FY 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii)) 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) (*http://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. 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 determinations, we proposed that the following procedures would apply to hospitals participating in the RHQDAPU program. These procedures are, for the most part, the same as the procedures that apply to the FY 2011 payment determination. We identified where we proposed to modify a procedure.

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.

• Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*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 proposed 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.

We did not receive any public comments related to our proposal for procedural requirements for the FY 2012, FY 2013 and FY 2014 payment determinations. We are adopting as final our proposal regarding the procedural requirements discussed above for the FY 2012, FY 2013 and FY 2014 payment determinations.

(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 proposed 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 HCAHPS, CDC NHSN, chart-abstracted measures, and structural measure quality measure data during the four calendar year quarters of FY 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 also proposed, beginning with the FY 2013 payment determination, to validate four discharge quarters, but the quarters will be the 4th calendar quarter of the year that occurs 2 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 the Hospital Value-Based Purchasing Program as authorized by section 3001(a)(1) of the Affordable Care Act 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, HCAHPS patient experience of care measures 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 would post a table outlining the discharge quarters that would 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 invited public comment on this proposal.

Comment: Many commenters supported the proposal to move all measures to a consistent timeframe, beginning with the FY 2013 payment determination, in anticipation of the transition to the HVBP program when all measures need to be calculated across a consistent timeframe. Commenters also indicated that the move provides clarity for the timeframe of data for each fiscal year.

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

Comment: Many commenters questioned CMS' intent related to the HVBP program requirements under section 3001 of the Affordable Care Act.

Response: We appreciate the comments and intend to propose regulations for the HVBP program consistent with the legislative mandates of section 3001 of the Affordable Care Act in the FY 2012 IPPS/LTCH PPS proposed rule.

After consideration of the public comments we received, we are adopting as final our proposal for synchronization of RHQDAPU program

data submission and validation quarters with quarters used to make payment determinations.

(3) HCAHPS Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

We proposed 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 proposed 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 proposed 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 proposed 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 Interactive Voice Response (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 again encouraged hospitals to regularly check the HCAHPS Web site at *http://www.hcahpsonline.org* for program updates and information.

Comment: Commenters expressed support for the use of the HCAHPS survey, but they suggested the development of additional survey domains.

Response: We thank the commenters for their input and will take their suggestions into consideration in developing future rulemaking.

After consideration of the public comments we received, we are adopting as final our proposed HCAHPS requirements for the FY 2012, FY 2013 and FY 2014 payment determinations.

b. Additional RHQDAPU Program Procedural Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

(1) Chart-Abstracted Measures for Which Data Are 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 proposed 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 proposed 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.

We did not receive any public comments related to this proposal. We are adopting as final our proposal related to chart-abstracted measures for which data is submitted directly to CMS (via QualityNet).

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 proposed 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 proposed 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 proposed 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.

We did not receive any public comments related to these proposals. We are adopting these proposals as final.

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 proposed 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 an 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 noted 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.

We did not receive any public comments related to this proposal. We are adopting as final our proposal related to the submission of aggregate population and sampling data for AMI, HF, PN, and SCIP topics.

(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.* If a hospital has zero HCAHPS-eligible discharges, the hospital must submit this information through the QIO Clinical Warehouse. The QIO Clinical Warehouse will accept zero HCAHPS-eligible discharges. Hospitals with zero HCAHPS-eligible discharges must submit their total number of HCAHPS-eligible cases to the QIO Clinical Warehouse for that month as part of their 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. Hospitals with five or fewer HCAHPS-eligible discharges must submit their total number of HCAHPS-eligible cases to the QIO Clinical Warehouse for that month as part of their quarterly HCAHPS data submission.

We did not receive any public comments related to this proposal. We are adopting as final our proposal related to data submission requirements for HCAHPS.

(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: 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*

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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. We use the existing Medicare fee-for-service claims to calculate the measures. For the FY 2012 payment determination, we 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, we 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.

We did not receive any public comments on this proposal. We are finalizing our proposal to use up to 3 years of discharges (based on Medicare claims) to calculate the claims-based measures as appropriate. For the FY 2012 payment determination, we would use up to 3 years of discharges prior to January 1, 2011 as appropriate for the measure. For the FY 2013 and FY 2014 payment determinations, we would use up to 3 years of discharges as appropriate for the measure prior to January 1, 2012, and January 1, 2013, respectively. In addition, 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 proposed 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 proposed 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.

We did not receive any public comments related to this proposal. We are adopting as final our proposal related to data submission requirements for structural measures.

(5) Data Submission of All-Patient Volume Data for Selected DRGs Related to RHQDAPU Program Measures

For submission of the all-patient volume data for selected DRGs, we proposed 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 Hospital Measure Specification Manual. Hospitals would begin submitting this data quarterly via QualityNet beginning with January 1, 2011 discharges.

We invited 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 proposed 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.

As we stated in our responses to comments on all-patient volume in section IV.A.3.b.(3) of this final rule, we are not finalizing the collection of all-patient volume data for selected MS–DRGs; therefore, we are not adopting the data submission requirements for all-patient volume data for selected MS–DRGs.

(6) Data Submission and Reporting Requirements for HAI Measures Reported via NHSN

We proposed that hospitals participating in the RHQDAPU program 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 proposed 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 proposed 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 proposed 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. We will access the reports in the NHSN and will compile the reports for RHQDAPU program and public reporting purposes.

We invited 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.

We previously discussed public comments on these data submission and reporting requirements for HAI measures reported via NHSN in section IV.A.3.(c)(3) of this final rule. We are adopting the CLABSI HAI measure for the FY 2013 payment determination and the SSI HAI measure for the FY 2014 payment determination. We are also finalizing the quarterly NHSN submission requirement. Requirements for NHSN participation, measure specifications, and data collection can be found at *http://www.cdc.gov/nhsn/.* Hospitals are encouraged to visit this Web site in order to enroll, and obtain the NHSN enrollment and reporting requirements. Training resources are also available there.

The collection of the CLABSI measure via the NHSN will begin with January 1, 2011 discharges, and the collection of the SSI measure will begin with January 1, 2012 discharges. The data collection and submission timeframes for the CLABSI measure for the FY 2012 payment determination are shown below. Hospitals must submit their quarterly data to NHSN for RHQDAPU purposes on or around the dates shown in the table below (updates to this will be posted on the QualityNet Web site).

SUBMISSION TIMEFRAMES FOR CLABSI MEASURE FOR THE FY 2012 PAYMENT DETERMINATION

CY 2011 Discharge dates	CDC–NHSN collection and quarterly report generation time frame	Final submission deadline for RHQDAPU FY 2012 payment determination
Q1 (Jan–Mar 2011)	April 30–August 15th	August 15, 2011.
Q2 (Apr–Jun 2011)	July 30–November 15th	November 15, 2011.
Q3 (Jul–Sep 2011)	September 30–Feb 15th	February 15, 2012.
Q4 (Oct–Dec 2011)	October 30th–May 15th	May 15, 2012.

Hospitals have until the RHQDAPU final submission deadline to submit their quarterly data to NHSN. After the final RHQDAPU submission deadline has occurred for each CY 2011 quarter, CMS will obtain the hospital-specific calculations that have been generated by the NHSN for the RHQDAPU program. Further details regarding data submission and reporting requirements for HAI measures specified for the RHQDAPU program to be reported via NHSN will be posted on CMS' QualityNet Web site in the fall of 2010.

(7) Data Submission Requirements for Registry-Based Measures

We proposed 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 proposed 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 the 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 the 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 proposed to 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 were discussed in a section IV.A.13. of the FY 2011 IPPS/LTCH PPS proposed rule. We proposed 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 anticipated 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 anticipated would be completed by December 31, 2010.

(A) Hospitals That Choose To Report the ICD Complications Measure

We proposed that if the hospital chooses the ICD Complications measure, it would submit specified data elements for specified populations to the qualified ICD registry, and that CMS intended to establish criteria and begin qualifying registries for this topic so that hospitals can begin submitting data for discharges beginning January 1, 2011. We proposed that 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. 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, we proposed that it would submit data on the measures listed for these topics to a qualified registry for the topic and that we intend 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. In addition, 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.

As we stated previously in section IV.A.3.(c) of this final rule, we are not finalizing the proposed registry-based measure topics. Therefore, we are not finalizing these proposed data submission requirements or the registry

qualification process discussed in section IV.A.13. of this final rule.

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 solicited 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 recognized that there were 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 proposed 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 invited public comment on this proposal.

Comment: A few commenters supported this proposal.

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

After consideration of the public comments we received, we are adopting as final our proposal related to RHQDAPU program disaster extensions and waivers.

7. 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/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 noted 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 section IV.A.5.a. of the proposed rule, 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 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 2011 payment update adopted in this final rule.

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

For FY 2013 and future years, we also proposed 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 proposed 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 proposed the following changes for FY 2013:

We proposed to validate the data submitted by a hospital if the hospital failed the previous year's RHQDAPU program validation. We proposed 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 proposed 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 proposed the following changes to the FY 2012 RHQDAPU validation random sample approach:

Starting in FY 2013, we proposed 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 proposed 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 FY 2013, we proposed 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 proposed 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 proposed 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 IV.A.5.a.(2) of the proposed rule (75 FR 23985 and 23986). 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.

Comment: One commenter was pleased that the proposed chart audit validation process takes into account all applicable chart-abstracted measures.

Response: We appreciate the comment and agree that the proposed approach ensures validation of all submitted RHQDAPU chart-abstracted measures by sampled hospitals.

Comment: One commenter recommended that all hospitals should be validated as opposed to a random sample to hold hospitals equally accountable.

Response: We thank the commenter for the recommendation. We weighed burden to hospitals, reliability of hospital validation results in sample size, and cost to the taxpayers through validation expenses when proposing the random sample. The annual random

sampling approach ensures equal probability of selection for all hospitals submitting sufficient data each year. Our proposed targeting approach also ensures that all hospitals will be validation at least once every four years. This targeting approach will increase equity in accountability in the validation of all hospitals' data over a four year period, while reducing burden to hospitals to copy and return validation records through random sampling.

Comment: One commenter supported CMS' proposal to implement the new validation process for FY 2012, as it minimizes burden for many hospitals and implements a more rigorous validation process compared to what is currently in place.

Response: We appreciate and agree with the commenter.

Comment: One commenter believed that CMS should understand specific, timely and frequent feedback from hospitals would prevent serial abstraction mistakes. The commenter gave an example of an abstractor who makes a mistake at the top of the algorithm and does not have any validation for 12–24 months. In this example, the commenter believed that serious validation mismatches could go unchecked for such long periods of time that a hospital could be put on the "targeted list" for validation because of failing previous validations as CMS describes and that the potential for a longstanding mismatch is greater when a mistake is not corrected through the quarterly educational comments specific to each facility. The commenter did not agree with CMS that providing validation feedback to a group of hospitals that did not get validated will correct abstraction errors for all.

Response: We appreciate the comment, but believe that the process we are finalizing starting in FY 2012 will improve the reliability of RHQDAPU annual and quarterly validation scores through the increased sample size from 5 records per quarter to 12 records per quarter. In addition, sample stratification of measure topics will ensure that CMS validates all chart-abstracted measures, thereby providing a more valid estimate of a hospital's overall abstraction accuracy for chart-abstracted RHQDAPU data.

We believe that the improved precision and reliability of our random and targeted validation proposed approaches outweigh the benefit of providing hospital-specific feedback to all hospitals. Hospitals have generally improved in their RHQDAPU abstraction accuracy since the program's inception, thereby lessening the need for regular quarterly hospital-specific feedback to all hospitals. In past several years, the vast majority of hospitals have submitted accurate data, as evidenced by 99.5 percent average percentage of hospitals passing our annual RHQDAPU validation requirement.

Comment: A commenter stated that the timeline for turn-in of medical charts of 45 days is fair and appreciated that a certified letter follows-up when records have not been received in 30 days by the CDAC. However, the commenter would like the opportunity to address when CDAC abstractions have missed key documentation that changes an answer. For example, the commenter had several cases where evidence of passing a measure on smoking cessation or CHF discharge instructions were in the chart, but the CDAC missed it.

Response: The CDAC reabstraction process is an independent reabstraction of the hospital's official medical record documentation. Additionally, hospitals may appeal quarterly scores below the passing threshold to their State QIO for an independent review. Hospitals that do not pass our annual RHQDAPU program validation requirement are eligible to appeal validation mismatched data elements reabstracted by CDAC for CMS reconsideration.

Comment: A commenter believed that CMS should be accountable regarding their CDAC abstractors and should require attestation by the CDAC abstractors that they received appropriate training on the Specifications Manual and its proper interpretation.

Response: Our abstractors receive extensive training from CDAC management and assisted by our contractors responsible for RHQDAPU measure maintenance and abstraction education to our QIOs. Additionally, we require our CDAC abstractors to pass inter-rater reliability tests relative to CDAC expert adjudicators. Historically, CDAC abstractor inter-rater reliability rates have averaged greater than 95 percent. We recognize that CDAC abstractors are not 100 percent accurate in their reabstraction, and the CDAC adjudicates all potential mismatches. Additionally, hospitals are eligible to appeal quarterly scores below the passing threshold to their state QIO for an independent review. Hospitals that do not pass our annual RHQDAPU validation requirement are eligible to appeal validation mismatched data elements reabstracted by CDAC for CMS reconsideration. Collectively, we believe that the CDAC abstraction process is accurate, but do provide multiple independent methods of appeal for hospitals that believe their abstraction is correct as compared to the CDAC reabstraction.

Comment: One commenter opposed modifying the quarterly stratified sample selection by reallocating sample cases when a hospital has submitted fewer than three cases in a topic within a quarter.

Response: We believe that our approach provides a more reliable validation estimate to ensure that hospitals are submitting accurate quality measure information. Our approach prevents reduction in sample size and retains reliability by maintaining a total quarterly sample size of 12 cases across all topics. We believe that this approach creates equal and minimal burden for all sampled hospitals.

Comment: A commenter disagreed with addition of two validation samples of three cases per hospital. The commenter believed that this process is very labor intensive as records have transitioned from paper to electronic records, requiring multiple queries within an electronic health record to obtain all of the necessary information.

Response: We appreciate the comment, and will consider adding technology to accept electronic health records in the future to reduce validation burden to hospitals using electronic health records. We recognize that many more hospitals will transition their recordkeeping to EHRs, and we want to provide the public with accurate quality data and maintain alignment with hospital recordkeeping practices. We also believe that validating all RHQDAPU chart-abstracted measures is one of many important elements to ensure accurate publicly reported RHQDAPU data.

Comment: Some commenters were concerned about the lack of CDC/NHSN data validation process in place that is similar to the current RHQDAPU program validation process. The commenters recommended that, before any measure is included in public reporting, an adequate validation mechanism must be in place.

Response: We agree with the commenter that CDC/NHSN should be validated. We are considering validating self-reported CDC/NHSN data by proposing two additional quarterly samples. One quarterly additional sample would validate NHSN measure data. We will solicit public comment when we propose improvements to our validation approach in future rulemaking.

After considering the public comments we received, we are adopting as final our proposed supplements to the chart validation process for the FY

2013 payment determination and subsequent FYs.

This RHQDAPU validation process meets the requirements set forth in section 1886(b)(3)(B)(viii)(XI) of the Act. This section states that:

> The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

Starting with the FY 2012 payment determination and continuing in subsequent fiscal years, the chart validation process audits 800 randomly selected hospitals for the discharge quarters as outlined in this section. This sample size is sufficient to validate more than 22 percent of subsection (d) hospitals for FY 2012 and ensure validity of the reporting program. Currently, this process validates 27 chart abstracted measures, including 7 AMI measures (AMI 1 through 8a), 4 Heart Failure measures (HF 1 through HF 4), 6 Pneumonia measures, and all 10 SCIP measures.

Validation of the HCAHPHS measure is conducted through our oversight activities. We provide oversight of all HCAHPS survey vendors and hospitals self-administering the survey in order to ensure that the data collection protocols are followed. We also provide oversight and validation through our review of Quality Assurance Plans, site visits, conference calls and detailed data analyses each quarter to ensure there are no anomalies found in the data. In particular, we use site visits to review all data collection activities, including data reviews tracking a discharged patient from sampling, survey administration and data submission.

Information reported through claims for the 24 RHQDAPU program measures for FY 2012 as described in this rule is already validated for accuracy by Medicare Administrative Contractors (MACs) to ensure accurate Medicare payments. We are considering validation methodologies for structural measures and NHSN data and will propose validation methodologies as appropriate in the future.

We believe that the validation processes described above ensures validity of measures used under the RHQDAPU reporting program. Our reconsideration process outlined in this section provides hospitals that do not meet our validation requirement with the opportunity to appeal mismatched data elements that result in mismatched measures. We believe that our reconsideration process provides hospitals with appeal opportunities when mismatched measures result in potential payment reduction.

In the proposed rule, we state that we are also considering additional changes to our validation approach for future years. Starting in FY 2014, we are considering adding two strata to the current RHQDAPU program validation sample of SCIP, AMI, HF, and PN cases. We are considering selecting two additional validation samples of three cases per selected hospital per quarter. One additional quarterly sample would enable us to validate the CLABSI and SSI measures that we proposed to add to the RHQDAPU program 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 proposed to add to the RHQDAPU measure set for FY 2014. Thus, we would be validating a total of 18 records per quarter per validated hospital in 6 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 to NHSN for the proposed CLABSI measure and the SSI 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 invited public comment on our validation proposals and considerations.

Comment: Regarding FY 2014, the commenter believed that the proposal to add 2 strata (increasing from 12–18 records per quarter) to the current program validation sample did not add value, but rather adds busywork with more cases to validate. The commenter believed that this makes annual validation a potential of near 80–100 records per validated facility and believed that this number was excessive and burdensome on the hospital to produce this volume in a short period of time.

Response: We understand the commenter's concern about burden, but must also consider accuracy of all chart-abstracted measures. Our random sampling approach reduces this burden to the majority of hospitals, since not all hospitals' data will be validated in a particular year. We will consider this comment in the future for future supplements to the RHQDAPU validation approach.

We noted that, starting with the FY 2015 payment determination, we are considering proposing 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 hospitals are selected for validation at least once every 4 years. We are considering this addition starting in FY 2015 because FY 2015 would be the fourth year that CMS would use the random validation approach (which begins in FY 2012 as adopted in this final rule).

We intend to propose this supplement starting with the FY 2015 payment determination to further improve the targeting criteria that we are adopting in this final rule beginning with FY 2013.

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 proposed requiring 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.

Comment: A commenter stated that the July 1, 2010 through August 15, 2010 period to report acknowledgement of data accuracy and completeness is over 1 year prior to the October 2011 start of FY 2012. Much of the data reported by hospitals to CMS occurs following this date.

Response: We agree with the commenter. Consistent with our FY 2010 requirement (74 FR 43890), we believe that a more appropriate period to report FY 2012 data accuracy and completeness is July 1, 2011 through August 15, 2011, not 2010 as proposed in the FY 2011 IPPS/LTCH PPS proposed rule. We are modifying the reporting period from our original proposal to provide hospitals with time to report more data applicable to the FY 2012 payment determination. We also intend to propose in the FY 2012 IPPS rule using the same July 1 through August 15 time reporting period in future payment years.

After consideration of the public comments we received, we are adopting as final our data accuracy and completeness acknowledgement requirements for the FY 2012 payment determination and subsequent years. However, we are requiring hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2011 and August 15, 2011 for data to be used for the FY 2012 RHQDAPU program payment determination instead of the proposed July 1, 2010 through August 15, 2010 timeframe.

9. 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 information regarding measures submitted under the RHQDAPU program available to the public. As we noted in section IV.A.1.g. of this final 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.

We did not receive any public comments on our proposal to continue using FY 2011 requirements for FY 2012 and subsequent years. We adopt as final our proposal regarding public display requirements.

10. 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 proposed that all hospitals submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).

For the FY 2011 payment determination, we proposed 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 proposed that if a hospital asks us to reconsider an adverse RHQDAPU program payment decision made because the hospital failed the validation requirement, the hospital must submit paper copies of all the medical records that it submitted to the CDAC contractor each quarter for purposes of the validation. Hospitals must submit this documentation to a CMS contractor. 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 IV.A.6.b. of this final rule, the State QIO is available to conduct a quarterly validation appeal if so requested by a hospital.)

For the FY 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 proposed that all hospitals submit a reconsideration request to CMS and receive a decision on that request prior to submitting a

PRRB appeal. We believe that the reconsideration process is less costly for both CMS and hospitals, and that this requirement will decrease the number of PRRB appeals by resolving issues earlier in the appeals process.

Following receipt of a request for reconsideration, we will—

- Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the request has been received.
- Provide written notification to the hospital CEO, using the contact information provided in the reconsideration request, regarding our decision. We expect the process to take approximately 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, 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 solicited public comments on the extent to which these proposed procedures will be less costly for hospitals, and whether they will lead to fewer PRRB appeals.

Comment: With respect to a hospital needing to receive a decision from CMS prior to submitting a PRRB appeal, some commenters requested that CMS consider the impact of 90 days without the annual payment update to a facility. Commenters stated that the wait for CMS's decision and an appeal to the PRRB would delay the process of appeal by months if not half of the year.

Response: We appreciate the commenters' concern with the timeframe of our reconsideration process. Our goal is to provide a thorough technical and programmatic reconsideration of our initial RHQDAPU decision in a timely manner. Generally, our review requires 60 to 90 days, and hospitals granted their full payment update during this process would not need PRRB review. We are reviewing and standardizing our reconsideration process in an effort to reduce the wait time, but this wait time is largely dependent on the number of received requests. We hope to reduce the 90-day wait period in future years.

Comment: A commenter disagreed with the proposed process to require hospitals to resubmit all paperwork submitted to the CDAC contractor for RHQDAPU reconsideration purposes, and instead proposed that the CDAC store all medical record documentation.

Response: We appreciate the comment. We considered the relative cost to CMS and the taxpayers for storing all hospitals' submitted validation records for an additional 12 to 18 months, relative to the proposed process. We estimate from previous RHQDAPU results that the proposed process would impact 20 or fewer hospitals annually, and believe that this total burden to hospital is less than the extra storage cost to CMS and the taxpayers.

After consideration of the public comments we received, we are adopting the proposed RHQDAPU reconsideration and appeals requirements without any changes.

11. RHQDAPU Program Withdrawal Deadlines

We proposed to accept RHQDAPU program withdrawal forms for the FY 2012 payment determination from hospitals until August 15, 2011. We proposed 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.

We did not receive any comments on our proposal. We are adopting as final our proposal regarding withdrawal deadlines without any changes.

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.

Comment: Many commenters applauded our work toward developing measure specifications for EHR-based data collection in the future. The commenters believed this approach would substantially reduce the reporting burden on hospitals. Commenters recommended that CMS adopt specifications that would limit inclusions to ADT, bed tracking, or ED tracking board tools for these data elements.

Response: We thank the commenters for their encouragement of our efforts to integrate EHR technology with the RHQDAPU program. We will take these comments regarding specifications into consideration when we look to adopt measures that can be collected via EHRs in the future.

Comment: Some commenters requested that CMS clarify whether becoming a meaningful user of EHR certified technology is a path to fulfill both the RHQDAPU participation requirement and the eligibility requirements for the HITECH incentive program for being a meaningful user of certified EHR technology.

Response: As we have indicated, we are actively seeking to provide an alternative of EHR-based submission for RHQDAPU measures that otherwise would require chart or manual abstraction. Prior to accepting measures through EHRs for RHQDAPU, as commenters have suggested, it would be necessary to assure that data submitted and results calculated are equivalent to that from chart or manual abstraction so that results would be reliable and consistent. As we proceed with new measures development we would anticipate that testing during the measure development process and EHR certification process would become sufficiently standardized that additional implementation testing would not be needed.

We note that some important RHQDAPU quality measures such as HCAHPS experience of care measures are based on survey data and do not lend themselves to EHR reporting. Similarly, certain outcome quality measures, such as the current RHQDAPU readmission measures, are based on claims rather than clinical data. Thus, not all RHQDAPU measures will necessarily be capable of being submitted through EHRs. As a consequence, not all RHQDAPU measures would necessarily be included in the HITECH EHR incentive program.

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 Secretary through 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.

Comment: A few commenters supported CMS in launching the EHR Testing of Inpatient Quality Measures voluntary pilot established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. The commenters suggested that the implementation of the electronic metrics effective January 1, 2012, should be contingent upon successful EHR testing by CMS so that the measures can be reported electronically and not via manual chart abstraction. A commenter stated that electronic-specified clinical quality measures should not be included in the RHQDAPU program until they are fully tested. The commenter cited the examples of the collection and transmission for the ED Throughput, Stroke and VTE measures which are undergoing HITSP and CMS testing. The commenter urged CMS to expedite its development and testing of eMeasures to no later than year end CY 2010. The commenter asked for clarification on the possibility of retirement of the chart-abstracted specifications for these three measure sets once they can be collected and transmitted electronically.

Response: As discussed previously, we agree with the commenter's concern about the importance of testing the electronic specifications of the clinical quality measures prior to accepting submission for EHRs for the RHQDAPU program. We note that the January 2010 Connectathon, and the 2010 Healthcare and Information Management Systems Society (HIMSS) Interoperability

Showcase conducted initial testing and demonstration of some of the Emergency Department (ED) Throughput, Venous Thromboembolism (VTE), and Stroke measures. It is our intent not to require duplicative reporting across programs. When the data collection and transmission can be achieved through certified EHR technology, we may be able to rely upon EHRs to transmit the data. However, whether chart abstraction remains an option as a data collection mechanism for a given measure set adopted for the RHQDAPU program will largely depend upon the prevalence of EHR adoption among RHQDAPU participating hospitals.

As additional electronic specifications for clinical quality measures are developing, we plan to conduct testing of the electronically specified measures simultaneously. Also, we expect that vendors and providers will continue the testing for data collection and transmission.

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 FY 2011 IPPS/LTCH PPS final rule do not implicate or implement any HITECH statutory provisions. Those provisions are the subject of separate rulemaking and public comment.

Comment: One commenter noted that in moving forward, CMS should focus on developing measures collected through EHRs rather than using manually intensive, chart-based measures through the RHQDAPU program. The commenter suggested that we follow a more methodical framework to prioritize and integrate measures into the RHQDAPU and EHR incentive program with a long-term goal of transitioning from RHQDAPU to the meaningful use criteria under the HITECH EHR program.

Response: We agree with the importance of developing electronic specifications for new measures that are developed. We expect over time that EHRs will be the primary source of quality measures data. To this end, we have spearheaded electronic refinement and standardization of data transmission and performance measures.

Comment: A number of commenters requested that CMS address the potential duplication of clinical quality measures selected for use in the RHQDAPU program, and the clinical quality measures chosen for eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) to demonstrate meaningful use of certified EHR technology under the HITECH EHR incentive program. The commenters urged CMS to avoid duplicative reporting burden by considering only clinical quality measures chosen for the RHQDAPU program for the meaningful use criteria in the EHR incentive program for eligible professionals, eligible hospitals and CAHs.

Response: The rationale for the selection of the eligible hospital and CAH measure under HITECH Act are discussed in the HITECH EHR final rule (75 FR 44314). The 15 hospital and CAH measures were electronically specified for use in the RHQDAPU program, with anticipated implementation once the necessary development and infrastructure implementation had been completed. We have included two of the HITECH measures in this final rule for FY 2014 payment determination, based on chart abstraction. We anticipate that we will provide an option of electronic submission of these measures.

Comment: Some commenters recommended that EPs, eligible hospitals and CAHs reporting to RHQDAPU program via a certified EHR should be deemed to have successfully reported in the EHR incentive program to satisfy the meaningful use criteria for clinical quality measures.

Response: The HITECH Act requires the Secretary to strive to avoid duplicative and redundant reporting for HITECH with respect to the RHQDAPU program. However, as discussed previously, RHQDAPU and HITECH are established as separate incentive programs with separate requirements. The authorizing statutes do not provide that qualifying for one program should result in a hospital being deemed to have qualified for the other. As the two programs would have little overlap in measures as finalized in this rule, we do not believe it would be appropriate to deem participation in the RHQDAPU program as meeting the requirements for successful reporting in the EHR incentive program. However, where feasible, we intend to align the data submission requirements for measures included in each program. As HIT enabled clinical data will allow for new measures to be developed, we will consider aligning the requirements of the two programs.

Comment: Many commenters suggested aligning clinical quality measure reporting across federal agencies such as with the Health Resources and Services Administration, and across programs, such as with the Children's Health Insurance Program, to avoid duplicative and redundant quality performance reporting.

Response: As discussed, we have always sought to avoid duplicative and redundant reporting across federal programs. We will seek to align more quality initiative programs in future rulemaking.

13. Qualification of Registries for RHQDAPU Data Submission

In section IV.A.3.c.(4) of the 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. We are not adopting our proposal for the registry-based measure topics in this final rule. We also will not be pursuing the qualification of registries for these topics at this time. Below is the process and requirements that we had proposed to use to determine whether a registry is qualified to collect and submit quality measure data for RHQDAPU and the comments received on the process.

We proposed to 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 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 noted, 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 proposed 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 Hospital Measure Specification 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; and
  - The measure results.
- The registry must agree to transmit quality measure data in a CMS-approved format. We expected that this CMS-specified record layout would 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 *http://www.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.

Comment: In general, while commenters agreed that the concept of registry qualification criteria would lead to more standardized collection and quality control of data collected by registries, they had numerous suggestions for improvement of the criteria listed, and believed that the proposed timeframe for qualification and subsequent implementation of data collection was overly ambitious. Some commenters recommended that any approved registry must have a robust, CMS-certified validation system that can test the data submitted and identify missing data. Some commenters suggested that there should be an alternative approach for data submission that does not mandate participation in a registry with an associated fee. Numerous commenters noted that the proposed requirement that as of January 1, 2010, the registry has been collecting such data from at least 750 hospitals is arbitrary and precludes smaller registries such as State and regional registries from participating. These commenters urged CMS to revise its criteria for the number of participating hospitals as of January 1, 2010, or to not consider a number of participating hospitals at all. Commenters also stated that the one-day interval between the publication of a list of qualified registries and the starting date for the reporting of measures beginning with required discharges is unreasonable. One commenter was concerned that the proposed timeline for registries gives little advance notice to hospitals to research options, budget

resources and prepare for participation. Commenters recommended that the registry eligibility criteria include current performance, data integrity, and capacity to support hospitals to capture reliable and valid data, and suggested that of core measure vendors and other specialty registries such as the acute stroke care registry created by Congress be eligible to qualify (The Paul Coverdell National Acute Stroke Registry (PCNASR/CDC)).

Response: We thank the commenters for their recommendations. We acknowledge the commenters' concerns and intend to reexamine our criteria and timeline based upon the public comment received. We are not finalizing our proposal to qualify registries for data collection for the four topics listed earlier in this final rule for data collection beginning with January 1, 2011 discharges. If we propose to qualify registries for RHQDAPU data collection in the future, we will take into considerations all of the comments we received.

14. RHQDAPU and Hospital Value Based Purchasing Program

CMS received many comments about the HVBP program under section 3001(a)(1) of the Affordable Care Act, including the potential use of RHQDAPU measures and the infrastructure for the HVBP program. We address comments related to RHQDAPU measures in the appropriate RHQDAPU measures section categorized by payment year for the measure. We did not propose any requirements for implementation of section 3001(a)(1) of the Affordable Care Act in this rule. In the coming months, we plan to convene at least one listening session or Open Door Forum to listen to public feedback about the HVBP program. We will consider this feedback when proposing HVBP program requirements in the future.

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. 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.

As discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23997 and 23998), 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we proposed policy changes 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 exist 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 the proposed rule (75 FR 23997 through 23998), we proposed 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.

We also stated that, under the proposed policy, hospitals would be required to 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 would be required to continue to use patient status code "02" (Discharged/Transferred to a Short-Term General Hospital for Inpatient Care) on IPPS claims. We noted 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.

Comment: One commenter asked whether there was an exemption from the policy for an acute care discharge to a SNF that was unrelated to the acute care inpatient stay.

Response: We did not propose to make any changes to the postacute transfer policy with respect to acute care discharges to SNFs. Therefore, we consider this comment to be outside the scope of the proposed rule. However, we note that the statute governing the postacute transfer policy does not provide for an exemption for unrelated discharges to SNFs. In other words, a case involving a patient who is transferred from an acute care hospital to a SNF for the provision of skilled nursing services would be covered under the postacute transfer policy whether or not the services provided at the SNF were related to the services provided in the acute care hospital.

Because we did not receive any other public comments on this proposal, we are adopting it as final, without modification. Specifically, we are adding 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.

C. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges that occurred before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount (as discussed in the FY 1993 IPPS final rule (59 FR 45404 through 45409)). Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH adjustment for RRCs such that they are not subject to the 12-percent cap on DSH payments 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 national median CMI value for FY 2011 includes data from all urban hospitals nationwide, and the 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 values are based on dischares occurring during FY 2009 (October 1, 2008 through September 30, 2009), and include bills posted to CMS' records through March 2010.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24000), we proposed that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 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. (We refer readers to the table set forth in the FY 2011 IPPS/LTCH PPS proposed rule at 75 FR 24000.)

Based on the latest available data (FY 2009 bills received through March 2010), 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—

- 1.5136; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The final median CMI values by region are set forth in the following table:

Region	Case-Mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2993
2. Middle Atlantic (PA, NJ, NY)	1.3582
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4567
4. East North Central (IL, IN, MI, OH, WI)	1.4251
5. East South Central (AL, KY, MS, TN)	1.3771
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4407
7. West South Central (AR, LA, OK, TX)	1.5240
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6204
9. Pacific (AK, CA, HI, OR, WA)	1.4861

A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its fiscal intermediary or MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24000 and 24001), we proposed 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 were the latest cost report data available at the time the proposed rule was developed.

Therefore, in the FY 2011 IPPS/LTCH PPS proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 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. (We refer readers to the table set forth in the FY 2011 IPPS/LTCH PPS proposed rule at 75 FR 24001.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that began during FY 2008, the final median numbers of discharges for urban hospitals by census region are set forth in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,713
2. Middle Atlantic (PA, NJ, NY)	11,346
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	11,393
4. East North Central (IL, IN, MI, OH, WI)	9,232
5. East South Central (AL, KY, MS, TN)	7,016
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,159
7. West South Central (AR, LA, OK, TX)	7,081
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,282
9. Pacific (AK, CA, HI, OR, WA)	8,622

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.

D. Payment Adjustment for Low-Volume Hospitals (§ 412.101)

1. Background

As discussed in the June 2, 2010 supplemental proposed rule (75 FR 309023 through 30925), section 1886(d)(12) of the Act, as added by section 406(a) of Public Law 108–173, provides for a payment adjustment to account for the higher costs per discharge for low-volume hospitals under the IPPS, effective beginning FY 2005. Sections 3125 and 10314 of the Affordable Care Act amended the definition of a low-volume hospital under section 1886(d)(12)(C) of the Act. Sections 3125 and 10314 of the Affordable Care Act also revised the methodology for calculating the payment adjustment for low-volume hospitals.

Prior to the amendments made by the Affordable Care Act, section 1886(d)(12)(C)(i) of the Act defined a low-volume hospital as "a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year." Section 1886(d)(12)(C)(ii) of the Act further stipulates that the term "discharge" means "an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under Part A." Therefore, the term "discharge" refers to total discharges, not merely Medicare discharges. Furthermore, under section 406(a) of Public Law 108–173, which initially added subparagraph (12) to section 1886(d) of the Act, the provision requires the Secretary to determine an applicable percentage increase for these low-volume hospitals based on the "empirical relationship" between "the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges." The statute thus mandates that the Secretary develop an empirically justifiable adjustment based on the relationship between costs and discharges for these low-volume hospitals. The statute also limits the adjustment to no more than 25 percent.

Based on an analysis we conducted for the FY 2005 IPPS final rule (69 FR 49099 through 49102), a 25 percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. In the FY 2006 IPPS final rule (70 FR 47432 through 47434), we stated that a multivariate analyses supported the existing low-volume adjustment implemented in FY 2005. Therefore, the low-volume adjustment of an additional 25 percent would continue to be provided for qualifying hospitals with less than 200 discharges.

2. Temporary Changes for FYs 2011 and 2012

As stated above, section 1886(d)(12) of the Act was amended by sections 3125 and 10314 of the Affordable Care Act. The changes made by these sections of the Affordable Care Act are effective only for discharges occurring during FYs 2011 and 2012. Beginning with FY 2013, the preexisting low-volume hospital payment adjustment and qualifying criteria, as implemented in FY 2005, will resume.

Sections 3125(3) and 10314(1) of the Affordable Care Act amended the qualifying criteria for low-volume hospitals under section 1886(d)(12)(C)(i) of the Act to make it easier for hospitals to qualify for the low-volume adjustment. Specifically, the revised provision specifies that, for FYs 2011 and 2012, a hospital qualifies as a low-volume hospital if it is "more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year." In addition, section 1886(d)(12)(D) of the Act, as added by section 3125(4) and amended by section 10314 of the Affordable Care Act, provides that the payment adjustment (the applicable percentage increase) is to be determined "using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under Part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year."

Section 3125(3)(A) of the Affordable Care Act revised the distance requirement for FYs 2011 and 2012 from "25 road miles" to "15 road miles" such that a low-volume hospital is required to be only more than 15 road miles, rather than more than 25 road miles, from another subsection (d) hospital for purposes of qualifying for the low-volume payment adjustment in FYs 2011 and 2012. Therefore, in the June 2, 2010 supplemental proposed rule, we proposed to revise our regulations at 42 CFR 412.101(b)(2)(ii) to provide that, to qualify for the low-volume adjustment in FYs 2011 and 2012, a hospital must be located more than 15 road miles from the nearest subsection (d) hospital. The statute specifies the 15 mile distance in "road miles." The existing regulations at § 412.101 also specify the current 25 mile distance requirement in "road miles," but do not provide a definition of the term "road miles." In the June 2, 2010 supplemental proposed rule, we proposed to define the term "road miles" consistent with the term "miles" as defined at § 412.92 for purposes of determining whether a hospital qualifies as a SCH. Specifically, § 412.92(c)(i) defines "miles" as "the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital." We noted that while the proposed change in the qualifying criteria from 25 to 15 road miles is applicable only for FYs 2011 and 2012, the proposed definition of "road miles" would continue to apply even after the distance requirement reverts to 25 road miles beginning in FY 2013.

Sections 3125(3)(B) and 10314(1) of the Affordable Care Act revised the discharge requirement for FYs 2011 and 2012 to less than 1,600 discharges of individuals entitled to, or enrolled for, benefis under Medicare Part A during a fiscal year. Prior to enactment of the Affordable Care Act, under section 1886(d)(12) of the Act, as added by section 406(a) of Public Law 108–173, the discharge requirement to qualify as a low-volume hospital is less than 800 total discharges annually, which includes discharges of both Medicare and non-Medicare patients. This discharge requirement will apply also for fiscal years after FY 2012.

Section 226(a) of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 or becomes disabled, provided that the individual is entitled to Social Security benefits under section

202 of the Act. Once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there is no Part A coverage of a specific inpatient stay. For example, a patient does not lose entitlement to Medicare Part A simply because the individual's Part A hospital benefits have been exhausted; other items and services (for example, skilled nursing services) still might be covered under Part A, and the patient would qualify for an additional 90 days of Part A hospital benefits if at least 60 days elapsed between the individual's first and second hospital stay (§ 409.60(a) and (b)(1) and § 409.61(a)(1) and (c) of the regulations).

In addition, beneficiaries who are enrolled in Medicare Advantage (MA) plans provided under Medicare Part C continue to meet all of the statutory criteria for entitlement to Part A benefits under section 226. First, in order to enroll in Medicare Part C, a beneficiary must be "entitled to benefits under Part A and enrolled under Part B" (section 1852(a)(1)(B)(i) of the Act). There is nothing in the Act that suggests that beneficiaries who enroll in a Part C plan forfeit their entitlement to Part A benefits. Second, once a beneficiary enrolls in Part C, the MA plan must provide the beneficiary with the benefits to which the enrollee is entitled under Medicare Part A, even though it may also provide for additional supplemental benefits (section 1852(a)(1)(A) of the Act). Third, under certain circumstances, Medicare Part A pays for care furnished to patients enrolled in Part C plans. For example, if, during the course of the year, the scope of benefits provided under Medicare Part A expands beyond a certain cost threshold due to Congressional action or a national coverage determination, Medicare Part A will pay the provider for the cost of those services directly (section 1852(a)(5) of the Act). Similarly, Medicare Part A also pays for federally qualified health center services and hospice care furnished to MA patients (section 1853(a)(4) and (h)(2) of the Act). Thus, a patient enrolled in a Part C plan remains entitled to benefits under Medicare Part A.

Accordingly, for purposes of determining the number of discharges for "individuals entitled to, or enrolled for, benefits under Part A," we proposed to include all discharges associated with individuals entitled to Part A, including discharges of individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and discharges of individuals enrolled in an MA plan under Medicare Part C. Because a hospital may only qualify for this adjustment if the hospital has fewer than 1,600 discharges for patients entitled to Part A, the hospital must submit a claim to Medicare on behalf of all Part A entitled individuals, including a no-pay claim for patients who are enrolled in Part C, in order for Medicare to assure that these discharges are included in the determination of whether the hospital has fewer than 1,600 discharges for patients entitled to Part A.

Section 3125(4) of the Affordable Care Act added section 1886(d)(12)(D) to the Act, and section 10314(2) of the Affordable Care Act modified section 1886(d)(12)(D) of the Act. Section 1886(d)(12)(D) of the Act modified the methodology for calculating the payment adjustment under section 1886(d)(12)(A) of the Act for low-volume hospitals for discharges occurring in FYs 2011 and 2012. For FY 2010 and prior fiscal years, and beginning again in FY 2013, sections 1886(d)(12)(A) and (B) of the Act require the Secretary to determine an applicable percentage increase for low-volume hospitals based on the "empirical relationship" between "the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges." The statute thus requires the Secretary to develop an empirically justifiable adjustment based on the relationship between costs and discharges for these low-volume hospitals. The statute also limits the adjustment to no more than 25 percent. Based on analyses we conducted for the FY 2005 IPPS final rule (69 FR 49099 through 49102) and the FY 2006 IPPS final rule (70 FR 47432 through 47434), a 25 percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. However, section 1886(d)(12)(D) of the Act, as added by the Affordable Care Act, provides that, for discharges occurring in FYs 2011 and 2012, the Secretary shall determine the applicable percentage increase using a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for hospitals with 200 or fewer Medicare discharges to 0 percent additional payment for hospitals with more than 1,600 Medicare discharges. In the June 2, 2010 supplemental proposed rule (75 FR 30925), we proposed to apply this payment adjustment based on increments of 100 discharges (beginning with more than 200 discharges), with the applicable percentage increase decreasing linearly in equal amounts by 1.6667 percent for every additional 100 Medicare discharges, with no payment adjustment for hospitals with more than 1,599 Medicare discharges. We did not propose an adjustment for a hospital with exactly 1,600 discharges because, as specified in section 1886(d)(12)(C)(i) of the Act, as amended, a hospital must have "less than" 1,600 discharges in order to qualify as a low-volume hospital. Consistent with the statute, we proposed that hospitals with 200 or fewer Medicare discharges would receive an applicable percentage increase of 25 percent. We proposed that the payment adjustment would be as determined below:

Medicare Discharge Range	Payment Adjustment (Percent Add-On)
1 – 200	25.0000
201 – 301	23.3333
301 – 400	21.6667
401 – 500	20.0000
501 – 600	18.3333
601 – 700	16.6667
701 – 800	15.0000
801 – 900	13.3333
901 – 1000	11.6667
1,001 – 1,100	10.0000
1,101 – 1,200	8.3333
1,201 – 1,300	6.6667
1,301 – 1,400	5.0000
1,401 – 1,500	3.3333
1,501 – 1,599	1.6667
1,600 or more	0.0000

While we proposed to revise the qualifying criteria and the payment adjustment for low-volume hospitals for FYs 2011 and 2012, consistent with the amendments made by the Affordable Care Act, we noted that we did not propose to modify the process for requesting and obtaining the low-volume hospital payment adjustment. In order to qualify, a hospital must provide to its fiscal intermediary or MAC sufficient evidence to document that it meets the number of Medicare discharges and distance requirements. The fiscal intermediary or MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment and, if so, the add-on percentage. The fiscal intermediary or MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume status, in order to determine whether or not the hospital meets the qualifying criteria. In the June 2, 2010 supplemental proposed rule (75 FR 30925), we also noted that currently a prior cost reporting period is used to determine if the hospital meets the discharge criteria to receive the low-volume payment adjustment in the current year.

In the June 2, 2010 supplemental proposed rule (75 FR 30925), we also noted that as compared to the existing methodology for determining the payment adjustment for low-volume hospitals, no hospital would receive a lower payment adjustment under our proposed methodology for FYs 2011 and 2012. Although the statute specifies that, for years other than FYs 2011 and 2012, a hospital is a low-volume hospital if it has less than 800 discharges, currently only hospitals with fewer than 200 discharges receive a payment adjustment, an additional 25 percent, because the statute requires that the adjustment be empirically based to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. Consistent with section 1886(d)(12)(D) of the Act, for FYs 2011 and 2012, we indicated that under our proposal we would continue to pay hospitals with fewer than 200 discharges a payment adjustment amount equal to an additional 25 percent.

We proposed to revise our regulations at § 412.101 to reflect our proposal outlined above. We also proposed a clarification to the existing regulations to indicate that a hospital must continue to qualify as a low-volume hospital in order to receive the payment adjustment in that year; that is, it is not based on a one-time qualification. Specifically, existing § 412.101(a)(3) states that "The fiscal intermediary makes the determination of the discharge count for purposes of determining a hospital's qualification for the adjustment based on the hospital's most recent submitted cost report." This may mistakenly be interpreted to mean that once a hospital qualifies as a low-volume hospital, no further qualification is needed.

Comment: Several commenters stated that the statute requires the low-volume payment adjustment to be made using a "continuous linear sliding scale," but that the proposed payment adjustments based on increments of 100 discharges are not continuous. The commenters requested the low-volume adjustment for FYs 2011 and 2012 be determined using a specific continuous, linear equation that they included in their comments. The commenters also stated that determining the payment adjustment using their submitted linear equation, rather than the proposed 100-discharge increments, would avoid a significant change in the payment adjustment for a hospital if the hospital experienced only a small change in its number of Medicare discharges from one year to the next.

Response: We disagree with the commenters that our proposal to determine the low-volume payment adjustment for FYs 2011 and 2012 based on increments of 100 discharges does not meet the "continuous linear sliding scale" statutory requirement. Our proposed methodology provided for a continuous linearly decreasing adjustment in the amount of a fixed percentage for every additional 100 Medicare discharges. However, after consideration of public comments regarding the "continuous linear sliding scale" specified by the statute for the low-volume payment adjustment for FYs 2011 and 2012, we agree that an adjustment based on the linear equation provided by the commenters would result in less fluctuation in the payment amount in situations in which the number of discharges varied slightly in both years. We believe this will assist hospitals in their annual fiscal planning. Therefore, in this final rule, we are

adopting the continuous linear sliding scale equation suggested by commenters, to determine the low-volume payment adjustment for FYs 2011 and 2012 for eligible low-volume hospitals with Medicare discharges of *more than 200* and *less than 1,600* (that is, from 201 to 1,599 Medicare discharges). Consistent with the statute and as we proposed, for FYs 2011 and 2012 for eligible low-volume hospitals with *200 or fewer* Medicare discharges, we are finalizing a low-volume payment adjustment of 25 percent. Therefore, under new § 412.101(c)(2), for FYs 2011 and 2012, the low-volume adjustment will be determined as follows:

- Low-volume hospitals with *200 or fewer* Medicare discharges will receive a low-volume adjustment of an additional 25 percent for each discharge.
- Low-volume hospitals with Medicare discharges of *more than 200* and *fewer than 1,600* will receive for each discharge a low-volume adjustment of an additional percent calculated using the formula: [(4/14) − (Medicare discharges/5600)].

Commenters have suggested that the correct formula to apply the linear scale specified in section 1886(d)(12)(D) of the Act is (4/14) − (Medicare discharges/5600). This mathematical interpretation is consistent with the plain language of section 1886(d)(12)(D) of the Act. For qualifying hospitals with fewer than 1,600 Medicare discharges but more than 200 Medicare discharges, the low-volume add-on payment is calculated by subtracting from 25 percent the proportion of payments associated with the Medicare discharges in excess of 200. That proportion is calculated by multiplying the Medicare discharges in excess of 200 by a fraction that is equal to the maximum available add-on payment (25 percent) divided by a number represented by the range of Medicare discharges for which this policy applies (1,600 minus 200, or 1,400).

In other words, for qualifying hospitals with fewer than 1,600 Medicare discharges but more than 200 Medicare discharges, the add-on payment is calculated using the following formula:

Low volume add-on payment = 0.25 − [(0.25/1400)*(Number of Medicare discharges − 200)] = (4/14) − (Medicare discharges/5600).

Our proposal had been to apply this formula through use of a linear scale that represented this formula for every 100 discharges. In light of the commenters' suggestion, we will apply this formula for each discharge. We believe this is an equally appropriate application of the statutory provision and that it creates a more precise calculation for the add-on payment.

As we proposed and described in greater detail above, in this final rule, we are revising the regulations to specify at § 412.101(a) that "Medicare discharges" means a discharge of inpatients entitled to Medicare Part A, including discharges associated with individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C. As stated above, beginning with FY 2013, that is, with discharges occurring on or after October 1, 2012, the existing low-volume hospital payment adjustment and qualifying criteria as implemented in FY 2005 will resume.

Comment: A few commenters asked for clarification regarding what is required of the hospital in order to receive the low-volume adjustment for FYs 2011 and 2012, that is, what is the process, what documentation is required to verify Medicare discharges, which data will be used, and can the distance from comparable hospitals be documented with Web-based tools such as MapQuest.

Response: In order to determine the low-volume adjustment for FYs 2011 and 2012, CMS will determine the number of Medicare discharges from the most recent available Medicare discharge data from the MedPAR files. These data will provide the number of discharges for individuals that are entitled to or enrolled for Medicare Part A, as required by statute. As noted elsewhere in this final rule, the MedPAR discharge data now include discharges for individuals enrolled in a MA organization under Medicare Part C and discharges for patients who are entitled to Medicare Part A, but whose Part A inpatient benefits have been exhausted or whose stay was not covered by Medicare. Therefore, for FY 2011, the low-volume payment adjustment will be determined using Medicare discharge data for FY 2009 from the March 2010 update of the MedPAR files, as these are the most recent available data. (We expect to use Medicare claims data for FY 2010 to determine the low-volume payment adjustment for FY 2012, as these will be the most recent available data at that time.)

Below we are providing a chart that lists the hospitals with fewer than 1,600 Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files. Eligibility for the low-volume payment adjustment for FY 2011 and FY 2012 is also dependent upon meeting the mileage criteria specified at § 412.101(b)(2)(ii), as finalized in this final rule.

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Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
010007	1,325	4.9107%
010008	389	21.6250%
010009	884	12.7857%
010015	560	18.5714%
010018	67	25.0000%
010021	897	12.5536%
010022	618	17.5357%
010025	1,511	1.5893%
010027	462	20.3214%
010032	413	21.1964%
010034	1,047	9.8750%
010043	295	23.3036%
010044	636	17.2143%
010045	877	12.9107%
010047	1,049	9.8393%
010050	727	15.5893%
010051	324	22.7857%
010052	618	17.5357%
010058	147	25.0000%
010059	1,075	9.3750%
010062	978	11.1071%
010064	132	25.0000%
010066	323	22.8036%
010069	754	15.1071%
010073	925	12.0536%
010086	1,238	6.4643%
010087	1,379	3.9464%
010091	328	22.7143%
010095	374	21.8929%
010097	761	14.9821%
010099	1,278	5.7500%
010101	1,392	3.7143%
010102	129	25.0000%
010108	1,217	6.8393%
010109	781	14.6250%
010110	526	19.1786%
010112	1,487	2.0179%
010120	1,115	8.6607%
010125	1,380	3.9286%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
010126	1,042	9.9643%
010128	528	19.1429%
010129	511	19.4464%
010130	527	19.1607%
010137	495	19.7321%
010138	319	22.8750%
010143	724	15.6429%
010145	1,556	0.7857%
010146	762	14.9643%
010148	1,286	5.6071%
010150	1,043	9.9464%
010152	1,259	6.0893%
010157	677	16.4821%
010158	1,473	2.2679%
010167	1,105	8.8393%
010169	797	14.3393%
020006	1,469	2.3393%
020008	488	19.8571%
020012	1,134	8.3214%
020017	1,563	0.6607%
020018	262	23.8929%
020024	849	13.4107%
020026	1,357	4.3393%
020027	304	23.1429%
030001	1,493	1.9107%
030022	1,444	2.7857%
030033	1,520	1.4286%
030062	1,244	6.3571%
030067	524	19.2143%
030068	662	16.7500%
030071	456	20.4286%
030073	771	14.8036%
030074	70	25.0000%
030077	22	25.0000%
030078	230	24.4643%
030084	476	20.0714%
030099	1	25.0000%
030100	1,547	0.9464%
030107	428	20.9286%
030108	268	23.7857%
030112	283	23.5179%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
030113	238	24.3214%
030118	1,431	3.0179%
030120	548	18.7857%
030123	1,544	1.0000%
030124	12	25.0000%
030125	6	25.0000%
030126	740	15.3571%
040001	1,141	8.1964%
040002	1,026	10.2500%
040011	1,283	5.6607%
040015	507	19.5179%
040018	938	11.8214%
040019	759	15.0179%
040047	611	17.6607%
040050	1,028	10.2143%
040051	1,179	7.5179%
040067	819	13.9464%
040069	587	18.0893%
040072	955	11.5179%
040074	1,028	10.2143%
040076	1,212	6.9286%
040080	1,233	6.5536%
040081	326	22.7500%
040085	1,066	9.5357%
040091	868	13.0714%
040132	4	25.0000%
040137	1,314	5.1071%
040142	883	12.8036%
040145	48	25.0000%
040147	1,306	5.2500%
040152	23	25.0000%
050008	1,319	5.0179%
050014	1,166	7.7500%
050016	1,341	4.6250%
050028	786	14.5357%
050040	756	15.0714%
050046	368	22.0000%
050054	960	11.4286%
050055	1,158	7.8929%
050067	640	17.1429%
050070	236	24.3571%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
050090	778	14.6786%
050091	715	15.8036%
050096	111	25.0000%
050110	979	11.0893%
050113	531	19.0893%
050127	1,363	4.2321%
050131	1,027	10.2321%
050136	1,267	5.9464%
050158	1,490	1.9643%
050159	1,427	3.0893%
050167	1,003	10.6607%
050173	405	21.3393%
050188	620	17.5000%
050189	353	22.2679%
050192	397	21.4821%
050193	812	14.0714%
050196	727	15.5893%
050205	546	18.8214%
050211	1,330	4.8214%
050219	1,200	7.1429%
050234	1,357	4.3393%
050248	802	14.2500%
050257	1,290	5.5357%
050276	1,239	6.4464%
050279	994	10.8214%
050296	861	13.1964%
050298	1,111	8.7321%
050301	1,583	0.3036%
050315	798	14.3214%
050320	1,259	6.0893%
050325	32	25.0000%
050342	1,526	1.3214%
050349	85	25.0000%
050352	781	14.6250%
050357	669	16.6250%
050366	827	13.8036%
050376	1,468	2.3571%
050378	1,212	6.9286%
050385	705	15.9821%
050397	200	25.0000%
050407	944	11.7143%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
050417	1,135	8.3036%
050423	443	20.6607%
050430	4	25.0000%
050434	472	20.1429%
050435	1,146	8.1071%
050448	1,030	10.1786%
050478	183	25.0000%
050517	1,270	5.8929%
050526	1,572	0.5000%
050528	508	19.5000%
050531	1,089	9.1250%
050537	957	11.4821%
050543	473	20.1250%
050545	47	25.0000%
050547	84	25.0000%
050548	29	25.0000%
050552	253	24.0536%
050568	1,184	7.4286%
050588	1,577	0.4107%
050608	1,032	10.1429%
050618	165	25.0000%
050641	781	14.6250%
050660	708	15.9286%
050662	3	25.0000%
050667	48	25.0000%
050668	58	25.0000%
050680	1,453	2.6250%
050682	1	25.0000%
050684	1,465	2.4107%
050688	1,251	6.2321%
050693	412	21.2143%
050694	186	25.0000%
050697	89	25.0000%
050708	888	12.7143%
050714	196	25.0000%
050717	238	24.3214%
050722	79	25.0000%
050723	391	21.5893%
050725	166	25.0000%
050726	390	21.6071%
050727	1,236	6.5000%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
050732	1,256	6.1429%
050733	347	22.3750%
050736	1,334	4.7500%
050738	875	12.9464%
050744	675	16.5179%
050745	638	17.1786%
050747	706	15.9643%
050748	243	24.2321%
050749	215	24.7321%
050751	97	25.0000%
050754	64	25.0000%
050758	1,178	7.5357%
050760	241	24.2679%
050762	21	25.0000%
050763	1,172	7.6429%
050765	591	18.0179%
050766	52	25.0000%
060004	1,196	7.2143%
060006	1,291	5.5179%
060008	908	12.3571%
060016	1,059	9.6607%
060018	1	25.0000%
060036	931	11.9464%
060043	159	25.0000%
060044	524	19.2143%
060049	435	20.8036%
060054	1,024	10.2857%
060071	1,492	1.9286%
060075	741	15.3393%
060076	790	14.4643%
060096	353	22.2679%
060103	705	15.9821%
060107	4	25.0000%
060115	13	25.0000%
060116	701	16.0536%
060117	153	25.0000%
060118	186	25.0000%
060121	60	25.0000%
060123	159	25.0000%
070004	1,197	7.1964%
070008	1,441	2.8393%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
070012	1,563	0.6607%
070015	1,223	6.7321%
070038	5	25.0000%
070039	622	17.4643%
070040	238	24.3214%
090008	1,502	1.7500%
100024	279	23.5893%
100048	688	16.2857%
100054	1,257	6.1250%
100069	1,432	3.0000%
100079	452	20.5000%
100081	601	17.8393%
100106	570	18.3929%
100130	473	20.1250%
100134	8	25.0000%
100139	209	24.8393%
100140	1,142	8.1786%
100142	1,517	1.4821%
100150	1,226	6.6786%
100160	444	20.6429%
100175	984	11.0000%
100211	1,584	0.2857%
100240	68	25.0000%
100277	216	24.7143%
100298	33	25.0000%
100308	1	25.0000%
100309	7	25.0000%
100310	29	25.0000%
100311	22	25.0000%
110015	976	11.1429%
110023	1,579	0.3750%
110026	600	17.8571%
110027	739	15.3750%
110032	1,559	0.7321%
110040	648	17.0000%
110041	1,179	7.5179%
110042	984	11.0000%
110044	857	13.2679%
110045	812	14.0714%
110046	1,428	3.0714%
110050	614	17.6071%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
110051	961	11.4107%
110059	626	17.3929%
110071	673	16.5536%
110073	929	11.9821%
110086	729	15.5536%
110092	1,197	7.1964%
110100	664	16.7143%
110101	616	17.5714%
110104	1,431	3.0179%
110109	903	12.4464%
110111	538	18.9643%
110112	275	23.6607%
110113	747	15.2321%
110121	496	19.7143%
110130	254	24.0357%
110132	1,068	9.5000%
110135	829	13.7679%
110142	734	15.4643%
110146	492	19.7857%
110153	1,123	8.5179%
110183	828	13.7857%
110187	749	15.1964%
110189	1,218	6.8214%
110190	406	21.3214%
110194	759	15.0179%
110200	695	16.1607%
110203	630	17.3214%
110205	542	18.8929%
110209	1,174	7.6071%
110212	1,042	9.9643%
110225	1,340	4.6429%
110226	1,137	8.2679%
110230	1,365	4.1964%
110231	19	25.0000%
120004	840	13.5714%
120010	1,283	5.6607%
120014	891	12.6607%
120019	599	17.8750%
120028	353	22.2679%
130024	810	14.1071%
130025	782	14.6071%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
130063	93	25.0000%
130065	261	23.9107%
130066	156	25.0000%
130067	7	25.0000%
130069	11	25.0000%
130070	11	25.0000%
140001	915	12.2321%
140019	758	15.0357%
140033	10	25.0000%
140059	883	12.8036%
140066	193	25.0000%
140068	1,294	5.4643%
140075	1	25.0000%
140077	638	17.1786%
140089	1,270	5.8929%
140094	1,444	2.7857%
140095	1,364	4.2143%
140100	289	23.4107%
140110	1,432	3.0000%
140137	512	19.4286%
140143	1,547	0.9464%
140145	958	11.4643%
140147	1,116	8.6429%
140151	1,504	1.7143%
140161	903	12.4464%
140167	1,372	4.0714%
140207	71	25.0000%
140210	1,261	6.0536%
140294	1,057	9.6964%
140300	940	11.7857%
140301	269	23.7679%
140303	379	21.8036%
150022	1,123	8.5179%
150038	803	14.2321%
150045	645	17.0536%
150057	1,367	4.1607%
150061	1,024	10.2857%
150064	1,243	6.3750%
150065	1,356	4.3571%
150072	820	13.9286%
150076	1,197	7.1964%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
150091	575	18.3036%
150097	1,334	4.7500%
150101	559	18.5893%
150102	519	19.3036%
150104	913	12.2679%
150129	818	13.9643%
150133	1,570	0.5357%
150146	749	15.1964%
150149	83	25.0000%
150150	1,080	9.2857%
150160	1,053	9.7679%
150163	811	14.0893%
150164	831	13.7321%
150165	440	20.7143%
150166	256	24.0000%
150167	633	17.2679%
150168	759	15.0179%
150170	11	25.0000%
150172	53	25.0000%
150174	14	25.0000%
150175	492	19.7857%
150176	5	25.0000%
160001	1,344	4.5714%
160005	1,057	9.6964%
160008	1,372	4.0714%
160013	695	16.1607%
160032	1,049	9.8393%
160040	645	17.0536%
160101	381	21.7679%
160104	1,516	1.5000%
160112	1,460	2.5000%
160122	975	11.1607%
160124	772	14.7857%
160147	892	12.6429%
160156	30	25.0000%
170001	1,542	1.0357%
170009	906	12.3929%
170010	597	17.9107%
170014	768	14.8571%
170017	810	14.1071%
170023	1,009	10.5536%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
170027	898	12.5357%
170033	693	16.1964%
170039	364	22.0714%
170058	1,112	8.7143%
170068	749	15.1964%
170074	687	16.3036%
170075	191	25.0000%
170094	688	16.2857%
170105	637	17.1964%
170109	388	21.6429%
170110	213	24.7679%
170120	1,301	5.3393%
170133	660	16.7857%
170150	498	19.6786%
170166	605	17.7679%
170175	1,073	9.4107%
170183	652	16.9286%
170186	1,473	2.2679%
170187	305	23.1250%
170188	260	23.9286%
170190	81	25.0000%
170191	288	23.4286%
170194	389	21.6250%
170195	340	22.5000%
170196	590	18.0357%
170198	93	25.0000%
170199	2	25.0000%
180004	1,184	7.4286%
180016	1,586	0.2500%
180019	1,482	2.1071%
180020	1,184	7.4286%
180024	901	12.4821%
180025	1,299	5.3750%
180043	1,443	2.8036%
180046	501	19.6250%
180049	1,287	5.5893%
180053	927	12.0179%
180064	836	13.6429%
180066	1,103	8.8750%
180070	960	11.4286%
180079	860	13.2143%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
180087	1,387	3.8036%
180092	863	13.1607%
180095	1,110	8.7500%
180101	946	11.6786%
180105	1,232	6.5714%
180106	1,235	6.5179%
180115	822	13.8929%
180117	632	17.2857%
180128	1,496	1.8571%
180138	1,402	3.5357%
180149	1,123	8.5179%
190001	926	12.0357%
190003	1,164	7.7857%
190005	1,268	5.9286%
190006	640	17.1429%
190007	1,241	6.4107%
190009	203	24.9464%
190011	717	15.7679%
190014	1,086	9.1786%
190025	1,080	9.2857%
190034	1,044	9.9286%
190037	1	25.0000%
190044	1,524	1.3571%
190050	1,229	6.6250%
190078	995	10.8036%
190079	413	21.1964%
190081	794	14.3929%
190088	674	16.5357%
190090	681	16.4107%
190099	916	12.2143%
190106	642	17.1071%
190114	1,034	10.1071%
190116	784	14.5714%
190118	736	15.4286%
190122	455	20.4464%
190128	295	23.3036%
190131	108	25.0000%
190133	193	25.0000%
190135	1,153	7.9821%
190140	814	14.0357%
190145	747	15.2321%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
190151	584	18.1429%
190161	138	25.0000%
190167	1,498	1.8214%
190175	1,311	5.1607%
190183	711	15.8750%
190184	380	21.7857%
190190	490	19.8214%
190191	486	19.8929%
190196	55	25.0000%
190199	19	25.0000%
190201	261	23.9107%
190208	452	20.5000%
190218	675	16.5179%
190241	70	25.0000%
190242	1,010	10.5357%
190245	118	25.0000%
190246	239	24.3036%
190250	1,329	4.8393%
190251	65	25.0000%
190255	12	25.0000%
190256	23	25.0000%
190257	213	24.7679%
190258	35	25.0000%
190259	220	24.6429%
190261	11	25.0000%
190263	1,372	4.0714%
190266	157	25.0000%
190267	79	25.0000%
190268	38	25.0000%
190270	304	23.1429%
190272	155	25.0000%
190273	49	25.0000%
190278	208	24.8571%
190297	246	24.1786%
200002	926	12.0357%
200018	1,146	8.1071%
200025	814	14.0357%
200031	1,074	9.3929%
200032	1,199	7.1607%
200037	1,406	3.4643%
200040	1,369	4.1250%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
200041	719	15.7321%
200050	1,591	0.1607%
200052	783	14.5893%
210017	1,242	6.3929%
210045	440	20.7143%
210060	1,251	6.2321%
220019	1,158	7.8929%
220025	226	24.5357%
220050	846	13.4643%
220051	1,325	4.9107%
220058	469	20.1964%
220075	378	21.8214%
220083	1,481	2.1250%
220095	1,524	1.3571%
220098	969	11.2679%
220162	276	23.6429%
220177	168	25.0000%
230003	1,057	9.6964%
230013	1,077	9.3393%
230015	779	14.6607%
230034	866	13.1071%
230035	1,315	5.0893%
230037	1,505	1.6964%
230040	1,513	1.5536%
230055	1,520	1.4286%
230060	745	15.2679%
230071	386	21.6786%
230078	450	20.5357%
230080	1,538	1.1071%
230085	365	22.0536%
230093	856	13.2857%
230095	1,573	0.4821%
230096	865	13.1250%
230100	1,398	3.6071%
230101	1,269	5.9107%
230106	1,362	4.2500%
230108	773	14.7679%
230110	1,283	5.6607%
230118	747	15.2321%
230133	753	15.1250%
230135	223	24.5893%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
230174	905	12.4107%
230180	1,281	5.6964%
230208	627	17.3750%
230212	636	17.2143%
230217	1,400	3.5714%
230239	1,262	6.0357%
230241	1,231	6.5893%
230257	151	25.0000%
230259	1,135	8.3036%
230264	18	25.0000%
230275	74	25.0000%
230279	174	25.0000%
230297	1,370	4.1071%
230301	217	24.6964%
240006	479	20.0179%
240014	739	15.3750%
240018	710	15.8929%
240019	1,118	8.6071%
240020	1,352	4.4286%
240022	529	19.1250%
240040	1,516	1.5000%
240043	1,467	2.3750%
240044	1,399	3.5893%
240050	1,322	4.9643%
240052	1,318	5.0357%
240059	805	14.1964%
240064	929	11.9821%
240069	921	12.1250%
240071	739	15.3750%
240076	1,164	7.7857%
240084	1,015	10.4464%
240088	1,532	1.2143%
240101	861	13.1964%
240117	1,458	2.5357%
240141	863	13.1607%
240166	1,038	10.0357%
240187	1,009	10.5536%
240196	177	25.0000%
240206	97	25.0000%
240211	2	25.0000%
250002	976	11.1429%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
250006	1,310	5.1786%
250010	520	19.2857%
250012	420	21.0714%
250017	668	16.6429%
250018	20	25.0000%
250020	1,121	8.5536%
250023	50	25.0000%
250027	354	22.2500%
250035	233	24.4107%
250036	957	11.4821%
250038	538	18.9643%
250043	588	18.0714%
250044	902	12.4643%
250049	771	14.8036%
250050	1,051	9.8036%
250051	174	25.0000%
250057	1,429	3.0536%
250059	933	11.9107%
250060	273	23.6964%
250061	641	17.1250%
250067	934	11.8929%
250077	1,071	9.4464%
250079	204	24.9286%
250081	1,384	3.8571%
250084	1,319	5.0179%
250085	871	13.0179%
250095	744	15.2857%
250112	145	25.0000%
250117	1,006	10.6071%
250124	1,133	8.3393%
250126	700	16.0714%
250127	30	25.0000%
250128	947	11.6607%
250134	136	25.0000%
250136	96	25.0000%
250149	358	22.1786%
250151	120	25.0000%
250152	10	25.0000%
250162	826	13.8214%
250163	2	25.0000%
260004	241	24.2679%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
260015	1,464	2.4286%
260021	1,003	10.6607%
260024	555	18.6607%
260034	889	12.6964%
260050	690	16.2500%
260057	885	12.7679%
260059	1,335	4.7321%
260061	528	19.1429%
260070	1,348	4.5000%
260074	1,305	5.2679%
260080	586	18.1071%
260097	1,114	8.6786%
260102	902	12.4643%
260115	790	14.4643%
260116	1,507	1.6607%
260142	933	11.9107%
260147	437	20.7679%
260160	834	13.6786%
260175	1,317	5.0536%
260178	1,065	9.5536%
260195	1,365	4.1964%
260207	616	17.5714%
260209	393	21.5536%
260211	461	20.3393%
260214	1,001	10.6964%
260219	799	14.3036%
260221	13	25.0000%
260222	36	25.0000%
260223	48	25.0000%
270002	726	15.6071%
270032	873	12.9821%
270074	241	24.2679%
270086	232	24.4286%
270087	301	23.1964%
280105	1,449	2.6964%
280111	1,149	8.0536%
280119	69	25.0000%
280127	314	22.9643%
280129	568	18.4286%
280131	211	24.8036%
290002	140	25.0000%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
290006	907	12.3750%
290008	758	15.0357%
290020	64	25.0000%
290027	80	25.0000%
290032	1,337	4.6964%
290049	1,504	1.7143%
290051	383	21.7321%
290055	32	25.0000%
310058	781	14.6250%
310088	700	16.0714%
310118	1,323	4.9464%
310120	770	14.8214%
320003	906	12.3929%
320011	747	15.2321%
320013	980	11.0714%
320014	1,012	10.5000%
320016	1,173	7.6250%
320017	1,278	5.7500%
320022	1,569	0.5536%
320030	403	21.3750%
320033	461	20.3393%
320037	260	23.9286%
320038	1,072	9.4286%
320057	76	25.0000%
320058	37	25.0000%
320059	772	14.7857%
320060	126	25.0000%
320061	681	16.4107%
320062	194	25.0000%
320065	1,068	9.5000%
320067	114	25.0000%
320069	560	18.5714%
320070	127	25.0000%
320074	1,302	5.3214%
320084	559	18.5893%
320086	624	17.4286%
320087	87	25.0000%
320088	53	25.0000%
330008	706	15.9643%
330010	10	25.0000%
330025	377	21.8393%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
330029	112	25.0000%
330033	1,064	9.5714%
330036	496	19.7143%
330037	724	15.6429%
330041	102	25.0000%
330049	1,429	3.0536%
330053	931	11.9464%
330075	421	21.0536%
330079	1,233	6.5536%
330084	1,214	6.8929%
330088	1,014	10.4643%
330096	1,036	10.0714%
330100	200	25.0000%
330111	771	14.8036%
330115	1,252	6.2143%
330132	1,419	3.2321%
330144	619	17.5179%
330151	1,188	7.3571%
330166	70	25.0000%
330177	488	19.8571%
330189	4	25.0000%
330197	1,552	0.8571%
330205	1,186	7.3929%
330211	1,551	0.8750%
330213	743	15.3036%
330223	1,379	3.9464%
330229	948	11.6429%
330238	1,024	10.2857%
330249	1,192	7.2857%
330263	541	18.9107%
330268	418	21.1071%
330276	1,401	3.5536%
330385	1,201	7.1250%
330403	4	25.0000%
330404	743	15.3036%
330405	497	19.6964%
330406	369	21.9821%
340011	1,379	3.9464%
340012	281	23.5536%
340035	1,250	6.2500%
340036	862	13.1786%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
340037	1,023	10.3036%
340038	1,496	1.8571%
340049	513	19.4107%
340055	1,323	4.9464%
340084	607	17.7321%
340085	1,592	0.1429%
340087	895	12.5893%
340120	806	14.1786%
340121	691	16.2321%
340127	1,044	9.9286%
340133	1,512	1.5714%
340138	36	25.0000%
340148	372	21.9286%
340156	221	24.6250%
340159	887	12.7321%
340160	1,576	0.4286%
340166	1,576	0.4286%
340168	36	25.0000%
350003	680	16.4286%
350009	287	23.4464%
350063	42	25.0000%
350064	6	25.0000%
360002	1,405	3.4821%
360013	1,347	4.5179%
360014	1,236	6.5000%
360029	1,581	0.3393%
360032	1,453	2.6250%
360038	871	13.0179%
360044	1,501	1.7679%
360046	1,081	9.2679%
360058	815	14.0179%
360071	1,100	8.9286%
360080	1,437	2.9107%
360089	1,309	5.1964%
360092	470	20.1786%
360107	932	11.9286%
360109	1,356	4.3571%
360116	712	15.8571%
360130	489	19.8393%
360148	555	18.6607%
360153	426	20.9643%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
360156	909	12.3393%
360170	1,076	9.3571%
360189	470	20.1786%
360197	1,304	5.2857%
360210	868	13.0714%
360245	359	22.1607%
360247	140	25.0000%
360261	19	25.0000%
360263	286	23.4643%
360266	1,487	2.0179%
360269	101	25.0000%
360270	821	13.9107%
360271	23	25.0000%
360274	176	25.0000%
360347	383	21.7321%
360348	943	11.7321%
360349	12	25.0000%
360350	91	25.0000%
360351	346	22.3929%
360352	19	25.0000%
360354	428	20.9286%
360355	20	25.0000%
360356	1	25.0000%
370002	970	11.2500%
370004	1,586	0.2500%
370007	316	22.9286%
370011	440	20.7143%
370015	562	18.5357%
370019	1,025	10.2679%
370029	726	15.6071%
370030	555	18.6607%
370036	436	20.7857%
370039	1,306	5.2500%
370040	1,241	6.4107%
370041	190	25.0000%
370048	982	11.0357%
370049	1,552	0.8571%
370051	376	21.8571%
370054	1,122	8.5357%
370057	554	18.6786%
370065	1,013	10.4821%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
370072	431	20.8750%
370080	361	22.1250%
370083	629	17.3393%
370084	499	19.6607%
370097	1,546	0.9643%
370099	1,191	7.3036%
370100	1,136	8.2857%
370103	400	21.4286%
370105	161	25.0000%
370112	420	21.0714%
370113	1,519	1.4464%
370138	349	22.3393%
370139	381	21.7679%
370148	1,262	6.0357%
370153	557	18.6250%
370156	786	14.5357%
370158	697	16.1250%
370166	806	14.1786%
370169	86	25.0000%
370170	62	25.0000%
370171	458	20.3929%
370172	252	24.0714%
370173	205	24.9107%
370178	992	10.8571%
370180	435	20.8036%
370183	501	19.6250%
370190	263	23.8750%
370192	153	25.0000%
370199	14	25.0000%
370201	108	25.0000%
370203	648	17.0000%
370206	310	23.0357%
370210	1,245	6.3393%
370211	1,117	8.6250%
370212	97	25.0000%
370214	33	25.0000%
370216	664	16.7143%
370218	854	13.3214%
370220	122	25.0000%
370222	1,530	1.2500%
370225	6	25.0000%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
370227	470	20.1786%
370228	491	19.8036%
370229	432	20.8571%
370231	15	25.0000%
370232	172	25.0000%
380001	1,020	10.3571%
380005	550	18.7500%
380021	1,331	4.8036%
380022	852	13.3571%
380029	428	20.9286%
380033	619	17.5179%
380037	815	14.0179%
380038	1,447	2.7321%
380040	1,083	9.2321%
380052	1,374	4.0357%
380056	438	20.7500%
380082	1,314	5.1071%
390003	979	11.0893%
390008	1,310	5.1786%
390019	1,180	7.5000%
390025	48	25.0000%
390035	1,054	9.7500%
390043	1,114	8.6786%
390056	1,030	10.1786%
390061	1,442	2.8214%
390062	809	14.1250%
390068	1,043	9.9464%
390071	1,022	10.3214%
390084	1,439	2.8750%
390095	1,289	5.5536%
390104	671	16.5893%
390112	813	14.0536%
390117	1,171	7.6607%
390122	1,040	10.0000%
390130	593	17.9821%
390131	812	14.0714%
390146	1,366	4.1786%
390150	1,216	6.8571%
390169	727	15.5893%
390176	23	25.0000%
390183	1,232	6.5714%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
390184	748	15.2143%
390189	1,598	0.0357%
390192	1,155	7.9464%
390194	1,353	4.4107%
390198	1,124	8.5000%
390199	1,235	6.5179%
390236	684	16.3571%
390266	968	11.2857%
390272	144	25.0000%
390278	594	17.9643%
390307	50	25.0000%
390312	233	24.4107%
390313	716	15.7857%
390314	398	21.4643%
390316	227	24.5179%
390317	2	25.0000%
390318	178	25.0000%
390319	130	25.0000%
390320	25	25.0000%
390321	19	25.0000%
410010	684	16.3571%
420005	1,240	6.4286%
420006	1	25.0000%
420011	574	18.3214%
420016	339	22.5179%
420019	906	12.3929%
420033	1,418	3.2500%
420037	775	14.7321%
420038	1,276	5.7857%
420039	1,123	8.5179%
420053	998	10.7500%
420054	639	17.1607%
420056	526	19.1786%
420057	327	22.7321%
420062	1,271	5.8750%
420066	516	19.3571%
420069	943	11.7321%
420072	483	19.9464%
420089	1,598	0.0357%
420101	453	20.4821%
420102	557	18.6250%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
420103	302	23.1786%
430008	585	18.1250%
430013	1,442	2.8214%
430015	837	13.6250%
430048	663	16.7321%
430060	21	25.0000%
430064	30	25.0000%
430081	144	25.0000%
430082	6	25.0000%
430083	28	25.0000%
430084	165	25.0000%
430089	382	21.7500%
430090	358	22.1786%
430091	504	19.5714%
430092	206	24.8929%
430093	80	25.0000%
430094	32	25.0000%
430096	156	25.0000%
440001	907	12.3750%
440007	851	13.3750%
440008	1,059	9.6607%
440010	541	18.9107%
440016	613	17.6250%
440020	973	11.1964%
440031	1,278	5.7500%
440032	764	14.9286%
440040	711	15.8750%
440047	410	21.2500%
440050	987	10.9464%
440051	1,080	9.2857%
440052	647	17.0179%
440054	891	12.6607%
440056	1,301	5.3393%
440057	1,249	6.2679%
440060	265	23.8393%
440061	1,507	1.6607%
440064	1,088	9.1429%
440067	1,374	4.0357%
440068	1,236	6.5000%
440070	740	15.3571%
440081	1,260	6.0714%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
440083	1,567	0.5893%
440084	1,573	0.4821%
440102	820	13.9286%
440105	51	25.0000%
440109	703	16.0179%
440110	1,068	9.5000%
440111	642	17.1071%
440115	510	19.4643%
440130	1,254	6.1786%
440131	701	16.0536%
440137	1,586	0.2500%
440141	541	18.9107%
440148	858	13.2500%
440153	950	11.6071%
440159	891	12.6607%
440168	395	21.5179%
440174	756	15.0714%
440180	945	11.6964%
440181	352	22.2857%
440182	683	16.3750%
440184	746	15.2500%
440186	948	11.6429%
440192	780	14.6429%
440200	399	21.4464%
440218	494	19.7500%
440225	11	25.0000%
440227	1,450	2.6786%
450005	829	13.7679%
450008	486	19.8929%
450018	1,362	4.2500%
450032	1,457	2.5536%
450052	540	18.9286%
450055	749	15.1964%
450073	516	19.3571%
450078	455	20.4464%
450080	1,469	2.3393%
450082	832	13.7143%
450085	540	18.9286%
450090	1,093	9.0536%
450099	1,045	9.9107%
450108	625	17.4107%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
450123	626	17.3929%
450143	507	19.5179%
450144	282	23.5357%
450154	1,119	8.5893%
450155	234	24.3929%
450162	674	16.5357%
450165	1,139	8.2321%
450177	954	11.5357%
450178	391	21.5893%
450187	746	15.2500%
450188	1,109	8.7679%
450191	84	25.0000%
450192	974	11.1786%
450194	991	10.8750%
450210	656	16.8571%
450214	1,163	7.8036%
450219	602	17.8214%
450221	472	20.1429%
450224	502	19.6071%
450234	862	13.1786%
450235	550	18.7500%
450236	1,354	4.3929%
450239	502	19.6071%
450241	262	23.8929%
450243	190	25.0000%
450253	428	20.9286%
450270	577	18.2679%
450283	509	19.4821%
450292	1,320	5.0000%
450293	259	23.9464%
450296	1,110	8.7500%
450306	172	25.0000%
450315	39	25.0000%
450347	1,426	3.1071%
450348	448	20.5714%
450351	1,194	7.2500%
450369	549	18.7679%
450370	573	18.3393%
450372	1,513	1.5536%
450373	326	22.7500%
450379	829	13.7679%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
450395	1,439	2.8750%
450399	500	19.6429%
450400	1,056	9.7143%
450411	747	15.2321%
450419	816	14.0000%
450422	7	25.0000%
450438	607	17.7321%
450446	474	20.1071%
450451	453	20.4821%
450460	517	19.3393%
450465	1,116	8.6429%
450475	946	11.6786%
450488	36	25.0000%
450489	236	24.3571%
450497	589	18.0536%
450498	373	21.9107%
450539	661	16.7679%
450547	729	15.5536%
450565	903	12.4464%
450573	779	14.6607%
450578	95	25.0000%
450580	1,180	7.5000%
450584	386	21.6786%
450586	420	21.0714%
450591	811	14.0893%
450596	1,124	8.5000%
450597	1,160	7.8571%
450605	411	21.2321%
450615	964	11.3571%
450620	257	23.9821%
450641	453	20.4821%
450653	1,238	6.4643%
450654	900	12.5000%
450658	520	19.2857%
450661	1,388	3.7857%
450674	199	25.0000%
450683	911	12.3036%
450690	1,511	1.5893%
450694	474	20.1071%
450698	358	22.1786%
450730	1,409	3.4107%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
450746	119	25.0000%
450749	302	23.1786%
450754	973	11.1964%
450755	408	21.2857%
450770	602	17.8214%
450774	147	25.0000%
450780	141	25.0000%
450795	155	25.0000%
450796	57	25.0000%
450797	7	25.0000%
450803	1,298	5.3929%
450804	1,018	10.3929%
450808	181	25.0000%
450813	408	21.2857%
450822	925	12.0536%
450825	310	23.0357%
450827	1,008	10.5714%
450830	17	25.0000%
450831	78	25.0000%
450833	988	10.9286%
450834	198	25.0000%
450839	468	20.2143%
450840	1,000	10.7143%
450841	364	22.0714%
450845	416	21.1429%
450848	1,156	7.9286%
450851	1,215	6.8750%
450853	473	20.1250%
450856	308	23.0714%
450860	101	25.0000%
450864	748	15.2143%
450865	144	25.0000%
450867	1,599	0.0179%
450871	358	22.1786%
450872	582	18.1786%
450874	52	25.0000%
450875	521	19.2679%
450877	1,103	8.8750%
450880	320	22.8571%
450883	51	25.0000%
450884	516	19.3571%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
450886	37	25.0000%
450888	192	25.0000%
450889	25	25.0000%
450891	89	25.0000%
450893	143	25.0000%
450894	129	25.0000%
460003	1,451	2.6607%
460007	888	12.7143%
460011	664	16.7143%
460013	1,060	9.6429%
460014	577	18.2679%
460015	1,373	4.0536%
460017	247	24.1607%
460018	38	25.0000%
460019	306	23.1071%
460023	1,310	5.1786%
460026	316	22.9286%
460030	364	22.0714%
460033	113	25.0000%
460035	187	25.0000%
460039	135	25.0000%
460041	1,256	6.1429%
460042	1,561	0.6964%
460043	5	25.0000%
460044	1,358	4.3214%
460049	671	16.5893%
460052	1,138	8.2500%
460054	268	23.7857%
460056	12	25.0000%
470001	1,397	3.6250%
470011	833	13.6964%
470024	925	12.0536%
480001	917	12.1964%
480002	893	12.6250%
490002	1,463	2.4464%
490012	1,596	0.0714%
490027	1,168	7.7143%
490033	1,006	10.6071%
490038	1,251	6.2321%
490084	1,068	9.5000%
490088	1,006	10.6071%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
490089	1,185	7.4107%
490092	1,319	5.0179%
490094	1,126	8.4643%
490097	1,409	3.4107%
490104	19	25.0000%
490105	21	25.0000%
490106	2	25.0000%
490108	362	22.1071%
490109	93	25.0000%
490111	1,193	7.2679%
490114	1,349	4.4821%
490117	572	18.3571%
490123	1,219	6.8036%
490127	1,126	8.4643%
490134	16	25.0000%
490135	192	25.0000%
490140	495	19.7321%
500007	1,316	5.0714%
500033	938	11.8214%
500037	409	21.2679%
500049	720	15.7143%
500052	3	25.0000%
500060	811	14.0893%
500084	619	17.5179%
500138	120	25.0000%
500143	110	25.0000%
500148	290	23.3929%
500151	876	12.9286%
510018	1,139	8.2321%
510026	750	15.1786%
510038	1,496	1.8571%
510053	521	19.2679%
510072	742	15.3214%
510077	1,193	7.2679%
510082	1,018	10.3929%
510085	1,430	3.0357%
510086	328	22.7143%
520011	1,347	4.5179%
520017	965	11.3393%
520019	1,531	1.2321%
520028	1,406	3.4643%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
520033	951	11.5893%
520034	1,319	5.0179%
520038	1,213	6.9107%
520041	900	12.5000%
520044	1,276	5.7857%
520057	915	12.2321%
520063	1,408	3.4286%
520064	743	15.3036%
520071	1,366	4.1786%
520076	1,072	9.4286%
520091	1,322	4.9643%
520095	931	11.9464%
520109	900	12.5000%
520116	1,289	5.5536%
520194	37	25.0000%
520196	161	25.0000%
520199	1,017	10.4107%
520204	186	25.0000%
520205	10	25.0000%
530002	813	14.0536%
530006	1,062	9.6071%
530008	611	17.6607%
530009	449	20.5536%
530010	642	17.1071%
530011	565	18.4821%
530015	657	16.8393%
530017	29	25.0000%
530025	735	15.4464%
530032	291	23.3750%
530033	300	23.2143%
640001	277	23.6250%
650001	1,587	0.2321%
660001	356	22.2143%
670002	858	13.2500%
670004	934	11.8929%
670005	22	25.0000%
670006	461	20.3393%
670008	215	24.7321%
670010	4	25.0000%
670011	421	21.0536%
670012	798	14.3214%

Provider Number	Medicare Discharges*	FY 2011 Low-Volume Payment Adjustment (Percentage Add-on)**
670018	126	25.0000%
670019	557	18.6250%
670025	1,531	1.2321%
670027	37	25.0000%
670029	99	25.0000%
670031	1,485	2.0536%
670033	6	25.0000%
670034	1,582	0.3214%
670040	3	25.0000%
670041	1,568	0.5714%
670042	2	25.0000%
670043	1,069	9.4821%
670044	1,120	8.5714%
670046	198	25.0000%
670048	97	25.0000%
670049	142	25.0000%
670050	186	25.0000%
670051	25	25.0000%
670052	502	19.6071%
670053	877	12.9107%
670054	101	25.0000%
670055	987	10.9464%

* Medicare discharges are based on data from the March 2010 update of the FY 2009 MedPAR files.

** Eligibility for the low-volume payment adjustment for FY 2011 is dependent upon meeting the mileage criteria specified at§ 412.101(b)(2)(ii) of the regulations.

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We note that this list of hospitals with fewer than 1,600 Medicare discharges does not reflect whether or not the hospital meets the mileage criterion, that is, the hospital also must be located more than 15 road miles from any other IPPS hospital. In order to receive the applicable low-volume percentage add-on payment, a hospital must notify and provide documentation to its fiscal intermediary or MAC that it meets this mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals is acceptable. The fiscal intermediary or MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles, as defined in the regulations at § 412.101(a)) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the fiscal intermediary or MAC will follow up with the hospital in order to obtain additional necessary information to determine whether or not the hospital meets the low-volume mileage criterion. The fiscal intermediary or MAC will refer to the hospital's Medicare discharge data determined by CMS (as shown in the chart above for FY 2011 and posted on the CMS Web site at: *http://www.cms.gov*) to determine whether or not the hospital meets the discharge criterion, and the amount of the payment adjustment, once it is determined that both the mileage and discharge criteria are met. The Medicare discharge data shown in the chart above, as well as the Medicare discharge data for all hospitals with claims in the March 2010 update of the FY 2009 MedPAR files, also will be available on the CMS Web site for hospitals to check their Medicare discharges to help them to decide whether or not to apply for low-volume hospital status. We are revising the regulations at § 412.101(b) to reflect the policy of basing the discharge criterion for FYs 2011 and 2012 (using Medicare discharges) on the most recently available MedPAR data. We will continue to base the discharge criterion (using total discharges, Medicare and non-Medicare) on the hospital's most recently submitted cost report data, as we do under the existing policy, for FY 2005 through FY 2010 and FY 2013 and subsequent fiscal years.

For FY 2011, the hospital should make its request for low-volume hospital status in writing to its fiscal intermediary or MAC by September 1, 2010, so that the applicable low-volume percentage add-on will be applied to payments for its discharges beginning on or after October 1, 2010. For FY 2012, a hospital that qualified for the low-volume adjustment in FY 2011 may continue to receive the add-on payment, without reapplying, if it continues to

meet the Medicare discharge criterion based on the latest available MedPAR data. However, the hospital must verify in writing to its fiscal intermediary or MAC that it continues to be more than 15 miles from any other IPPS hospital. (As noted above, we expect Medicare claims data from FY 2010 to be available to determine the low-volume payment adjustment for FY 2012.) A hospital that was not a low-volume hospital in FY 2011, and believes it meets the discharge and mileage criterion for FY 2012, should make its request in writing, with documentation that it meets the mileage criterion, to its fiscal intermediary or MAC by September 1, 2011, in order for the applicable low-volume percentage add-on to be applied beginning with discharges on or after October 1, 2011.

Comment: A few commenters requested clarification regarding the application of the low-volume payment adjustment at section 1886(d)(12) of the Act to SCHs and MDHs, given that these types of hospitals are also subsection (d) hospitals. These commenters also requested that CMS explicitly state that the applicable low-volume percentage add-on is applied to an SCH's or a MDH's payments at the Federal rate or the hospital-specific rate.

Response: Section 1886(d)(12)(C)(i) defines a low-volume hospital, in part, as a "subsection (d) hospital." SCHs and MDHs are "subsection (d) hospitals" although they can be paid under a hospital-specific rate instead of under the Federal standardized amount under the IPPS. As subsection (d) hospitals, SCHs and MDHs are eligible to receive the low-volume adjustment if the hospital meets the discharge and mileage criteria. Section 1886(d)(12)(A) states that the applicable low-volume percentage add-on payment will be "[i]n addition to any payments calculated [under section 1886]". For SCHs and MDHs, payment under section 1886 is determined using either the Federal rate or the hospital-specific rate, whichever results in a greater payment.

After consideration of the public comments we received, we are adopting the continuous linear sliding scale equation set forth by commenters to determine the low-volume payment adjustment for FYs 2011 and 2012 for eligible low-volume hospitals with Medicare discharges of *more than 200* and *less than 1,600* (that is, from 201 to 1,599 Medicare discharges), and we have modified § 412.101(c)(2) of the regulations in this final rule accordingly. We are revising § 412.101 to reflect the final changes as discussed above. In addition, we note that we are making structural changes to the final regulation text at § 412.101 as compared to the proposed regulation text at § 412.101(for example, we are combining proposed paragraph (b)(2)(iii) into paragraph (b)(2)(i) to more concisely reflect the final policy that we are establishing in this final rule).

E. 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 FYs 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 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 Final Rule

We refer readers to section IV.H.2. and IV.H.3. of the preamble of this final rule for a discussion of changes to the policies for identifying "approved medical residency programs" and the electronic submission of Medicare GME affiliation agreements.

F. 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

As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24002), 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 historically 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, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.

4. CMS' 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. As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule, 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.

As stated in the proposed rule, 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 proposed to use in our revised match process was the SSI eligibility data file, which contains a unique SSN for every SSI record and could include as many as 10 different historical Title II numbers for the records related to one individual. We proposed 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 noted 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 proposed to use in our revised match process was the MedPAR file. Hospitals submit claims to Medicare for inpatient services provided to Medicare beneficiaries. These claims are eventually accumulated in the MedPAR database. We noted 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, in the proposed rule, we proposed 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. We proposed to use the SSI eligibility file provided by SSA 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 proposed 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 would be included in our revised match process and compared to any and all HICANs in MedPAR. We noted that by including this second step (that is, adding all Title II numbers not previously identified by Step 1), we were 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 the earnings history of a spouse who 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 proposed 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 would attempt to match the beneficiary's HICAN in the MedPAR file. Specifically, we proposed 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 did not propose 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.

Comment: Many commenters supported the proposed data matching process and applauded CMS for working to refine the data matching process and for sharing details of the process in the proposed rule. Some commenters stated that it was difficult to determine the accuracy of the proposed data matching process without more details about the matching process, including more information on steps, testing, and validation processes or, alternatively, providing the underlying data files to the hospitals. Some commenters asked that CMS ensure that all HICANs included in the MedPAR file match to a HICAN in the EDB. The commenters requested that CMS exclude any HICANs from the MedPAR file that did not match to the EDB so that the SSI fractions would not be understated. Commenters also asked that CMS ensure that the proposed data matching process is consistent with Federal Information Processing Standards (FIPS). One commenter asked that CMS include SSI indicators in the EDB and give access to authorized parties so that hospitals can calculate their own SSI fractions and litigation over the SSI fractions would be reduced.

Response: We appreciate the commenters' support of our proposed data matching process. We believe that the proposed data matching process will produce more accurate SSI fractions. We also believe that we have shared all relevant details about the proposed revised data matching process in order to allow the public a meaningful opportunity to submit comments. Specifically, we have described the specific data files we intend to use, provided information and background about those data files along with a detailed, step-by-step description of how we intend to use those files for purposes of the data matching process, and provided specific information, including examples, of the specific timeframes in which we intend to conduct the various aspects of the data matching processes. However, per the commenters' request, we are sharing additional details in this final rule about the testing and validation procedures we intend to use. Specifically, as part of our internal data validation processes, we will track certain summary statistics in an effort to minimize any errors or omissions of data that might lead to inaccurate SSI fractions. The summary statistics we produce when calculating each fiscal year's SSI fractions for FY 2011 and beyond will include the number of SSI records received from SSA and will include at least all of the following information about SSI records that "matched" to Medicare inpatient hospital claims using the revised data matching process: (1) The number of SSI records matched using the new data matching process; (2) the number of records indicating that the individual is deceased; and (3) the number of records where at least one SSI monthly indicator reflects that the individual was in forced pay or forced due status. Additionally, we will produce summary statistics relating to SSI records that did not match to a Medicare inpatient claim, and will include at least all of the following information: (1) The number of unmatched SSI records with no Title II numbers; (2) the number of unmatched SSI records with one or

more Title II numbers; and (3) the number of records in the EDB with a HICAN, but no SSN. As these data will be used as part of our internal data validation process, we do not intend to provide them to the public.

In response to the comment requesting that we ensure that every HICAN on the MedPAR file match a HICAN in the EDB, we agree that every HICAN in the MedPAR file should match a HICAN in the EDB. We believe that this is necessarily the case because a Medicare claim must be submitted with a valid HICAN in order to populate the MedPAR database. As we stated in the proposed rule, the EDB is CMS' system of records for all individuals who have ever been enrolled in Medicare and includes SSNs as well as all of an individual's (current and historical) HICANs. The MedPAR file includes the HICAN under which the Medicare beneficiary received hospital benefits for a particular inpatient stay. Therefore, there should not be a HICAN in the MedPAR file that does not match to a HICAN in the EDB. Because there is no apparent reason for there to be a case where a HICAN in the MedPAR file did not match to a HICAN in the EDB, we did not propose to match HICANs in the MedPAR file to those in the EDB. We also note that "Step 3" of our proposed process should ensure consistency between the HICANs in the EDB and those in the MedPAR file by "equating" (or converting) the BIC identifiers in the EDB to the identifiers that are on the inpatient claim that is included in the MedPAR file. We also proposed 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 in steps 1 or 2 of the proposed data matching process, we would attempt to match directly to the beneficiary's HICAN in the MedPAR file. Specifically, we proposed to 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, but the MedPAR file indicated that the person had received Medicare services, the individual would be included in the data match process by this third step. We believe that this step further helps us to capture any SSI-entitled individual who is receiving Medicare benefits based on his or her own account. However, after consideration of this public comment, in an attempt to provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay, we will add this step to our validation procedures when conducting the data matching process. That is, we will test the MedPAR data to determine whether each HICAN in the MedPAR file matches to a HICAN in the EDB. In the unlikely event that we find a HICAN in the MedPAR file that we are not able to locate in the EDB, we will investigate the record to determine whether the HICAN is valid (in which case we would include it in our data matching process). However, if we find that the HICAN is not valid, we are adopting a policy to exclude that record from the data matching process, and we also will exclude that invalid record from the calculation of both the numerator and the denominator of the SSI fraction.

With respect to the comment about FIPS, we note that the data matching process is consistent with the FIPS, to the extent the data used in the data matching process are covered under FIPS.

In response to the comment that we populate the EDB with the monthly SSI indicators and grant access to certain members of the public so that hospitals could calculate their own SSI fractions, we note that the EDB contains several elements of protected personally identifiable information and is the sole system of records for Medicare eligibility. As such, we may only provide access to the EDB to persons authorized under the Privacy Act or the HIPAA Privacy Rule. However, we agree that there are advantages to allowing hospitals to compute their own SSI fraction and provide supporting documentation for the amount of DSH claimed, consistent with the process under the regulations for computing the Medicaid fraction. We are open to suggestions from the public regarding how CMS and SSA could provide the data necessary for hospitals to compute their own SSI fractions without compromising protected personally identifiable information and other protected information. We also welcome suggestions describing how CMS or its contractors should verify the accuracy of the hospitals' computations without significantly increasing administrative burden.

Comment: A few commenters requested that CMS release each hospital's detailed SSI fraction data or give hospitals access to patient-level detail data, including SSI eligibility information, so each hospital could determine the accuracy of its SSI fractions. One commenter asked that CMS publish both the Federal fiscal year SSI fractions and each hospital's cost reporting period SSI fractions. Some commenters asked that CMS provide assurances that there are no other data errors or omissions in the SSI file or the data matching process and asked that CMS work collaboratively with SSA to ensure the accuracy of the SSI file and to obtain SSNs for records in the EDB that are missing an SSN.

Response: Under the proposed data matching process for FY 2011 and beyond, CMS will continue to share certain detailed SSI fraction data used to calculate the hospital's SSI fraction as long as the hospital has a valid data use agreement with CMS and submits a request for such data. More detail on obtaining these data may be found on our Web site at: *http://www.cms.gov/PrivProtectedData/07_DSHRateData.asp* and the data use agreement application may be found on our Web site at: *http://cmsnet.cms.hhs.gov/hpages/oisnew/sysndata/access_to_data/cms-DUA.pdf.* As we stated in the proposed rule, we publish these data for every hospital based on the Federal fiscal year but, 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. We believe that the statute governing the SSI fraction (section 1886(d)(5)(F)(vi)(I) of the Act) requires that one SSI fraction be calculated and used for purposes of determining a hospital's disproportionate patient percentage. We believe that allowing individual hospitals to request their own cost reporting period SSI fractions is sufficient and goes above and beyond what the statute requires. The current policy of calculating all hospitals' SSI fractions based on the Federal fiscal year does not require that we maintain a list of each individual hospital's cost reporting period, nor does it require that we perform multiple iterations of the data matching process. It would be administratively unwieldy to not only track every hospital's cost reporting period, but to calculate SSI fractions based on the many different cost reporting periods that hospitals across the country may have.

With respect to the comment requesting that CMS work with SSA to ensure accuracy of the SSI file, we note that CMS has worked collaboratively with SSA throughout the development of the data matching process that was described in the FY 2011 proposed rule.

We are committed to continue working with SSA to ensure that the file we receive from SSA for the purposes of the SSI fraction data matching process is complete and comprehensive and includes all individuals who are entitled to SSI. To our knowledge, there are no omissions or data errors on the SSI file that we receive from SSA. If we become aware of any such omissions or errors, we will work with SSA to correct them as quickly as possible. With respect to obtaining an SSN for each record in the EBD that does not have an SSN, we remind the commenters 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." There are valid reasons that a person in the EDB may not have an SSN. For example, as we noted in the proposed rule, a person could live in a country other than the United States, but be entitled to Medicare benefits through his or her spouse. Another example of a record in the EDB that may validly lack an SSN is if the person filed for a spouse's or widow/er's benefit prior to the 1980's because SSA did not require that the person filing for benefits have an SSN at that time. There may be other valid reasons that a record in the EDB does not have an SSN, and as we previously stated, less than 0.07 percent of records in the EDB lack an SSN. We do not believe that it is possible to add an SSN for every record if the person became entitled to Title II or Medicare benefits without ever applying or receiving an SSN. However, we note that the EDB is populated by SSA on a frequent basis; to the extent that a record is added to the EDB, the SSN that SSA has on file for that person should be included in the EDB as well. Moreover, even if there were instances in which a record in the EDB was missing an SSN, the lack of an SSN for certain records in the EDB should have no effect on the data matching process because, in order to be entitled to SSI benefits, an individual must have an SSN. That is, a person who does not have an SSN, by definition, cannot be entitled to SSI. (We refer readers to the proposed rule language at 75 FR 24003 that states: "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. Additionally, as we stated under Step 2 of the proposed data matching process, 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.

In response to the comment that CMS share the SSI file data with hospitals, the SSI program is under the authority of SSA and CMS is not authorized to share SSA data. Additionally, CMS is only permitted to use the SSI data for the sole purpose of conducting the data match process and calculating the SSI fractions. To the extent that a third party wishes to obtain direct access to the SSI file, it must contact SSA directly and meet SSA's requirements to become an authorized user.

Comment: One commenter stated that CMS uses total (that is, "paid and unpaid") Medicare days in the denominator of the SSI fraction, but uses paid SSI days in the numerator of the SSI fraction. The commenter requested that CMS interpret the word "entitled" to mean "paid" for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:

- E01 and E02
- N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
- P01
- S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91
- T01, T20, T22, and T31

Response: In response to the comment that we are incorrectly applying a different standard in interpreting the word "entitled" with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also "*entitled* to supplemental security income benefits (excluding any State supplementation)" (emphasis added).[19] Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect "entitlement to" receive SSI benefits. Section 1602 of the Act provides that "[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be *paid* benefits by the Commissioner of the Social Security" (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

On the other hand, section 226 of the Act provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a

[19] As a side note, we have used the phrase "SSI-eligible" interchangeably with the term "SSI-entitled" in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

specific inpatient stay. Entitlement to Medicare Part A reflects an *individual's* entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used. SSI entitlement can change from time to time, and we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits.

After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process in response to public comments to provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay.

c. Timing of the Match

One of the district court's findings in the *Baystate* decision was that CMS did not use a more recent SSI entitlement 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 entitled, 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 entitlement 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 entitlement data during our completion of the revised match process in 2009. However, we stated our belief that further consideration of the timing of both the SSI entitlement information that SSA provides to CMS and our proposed revised match process for FY 2011 and subsequent fiscal years was warranted.

At present, SSA provides an annual file to CMS with SSI entitlement 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 entitlement information we currently use contains 6 to 18 months worth of retroactive SSI entitlement 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 entitlement information could actually be longer or shorter for some hospitals, depending on the hospital's specific cost reporting period. The 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 IPPS final 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. 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). Section 6404 of the Affordable Care Act 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. Therefore, Medicare claims for hospital services furnished in FY 2011 would have to be submitted no later than September 30, 2012.

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 the claims submission deadline. 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 very likely to be 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.[20] 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. 100–04), all IPPS hospitals that do not qualify for IME payments, direct GME payments, or nursing and allied health (N&AH) payments are specifically directed to submit informational-only claims for all MA inpatients to ensure that all data for MA beneficiaries are included in the SSI fraction. Accordingly, we indicated that we also were 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 current timing requirements for when hospitals must submit these claims 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 proposed to use more recent SSI eligibility information from SSA and a more updated version of the MedPAR file 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 proposed 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, under our proposal, 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 the Affordable Care Act, 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.

We proposed that the FY 2011 SSI fractions would 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 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,

[20] Teaching hospitals have an incentive to submit these claims as close as possible to the date of the patient's discharge because these claims are used, in part, to compute those hospitals' indirect graduate medical education payments. 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 as close as possible to the date of the patient's discharge, 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.

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.

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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 Entitlement File	Cost Reports Normally Accepted	Cost Report Final Settlement	SSI Fraction Available
Cost reports beginning October 1, 2010 through September 30, 2011	September 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 Final Rule

Cost Reports That Use the FY 2011 SSI Ratios	Deadline for Timely Filing of Claims	MedPAR File Used	SSI Entitlement File	Cost Reports Normally Accepted	Cost Report Final Settlement	SSI Fraction Available
Cost reports beginning October 1, 2010 through September 30, 2011	September 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

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Comment: Many commenters supported the proposed timing of the data matching process. Some commenters asked that CMS explain how cost report settlement would coincide with the proposed timing. Specifically, commenters asked whether contractors would issue Notices of Program Reimbursement prior to the availability of the SSI fractions. One commenter asked that CMS calculate an additional SSI fraction at the time of cost report audit for cost reports that are audited after the initial SSI fractions are published. One commenter noted that under the proposed timeline for calculating the SSI fractions, some hospitals would have already submitted their cost reports and had desk reviews and audits before the release of the SSI fractions. In particular, some commenters were concerned that hospitals with fiscal years beginning between October 1 and December 1 would have their cost reports settled before the release of the SSI fractions. One commenter cited Medicare Financial Management Manual Publication 100–06, Chapter 8, Section 90 that requires final settlement of cost reports within 12 months of acceptance. Commenters are concerned that the 12-month cost report settlement deadline may occur before the publication of the SSI fractions for certain cost reporting periods. Commenters questioned whether CMS will instruct Medicare contractors to hold the Notice of Program Reimbursement until the SSI fractions are released or will the contractors settle cost reports using the prior year's SSI fraction. In addition, commenters questioned whether contractors would automatically re-open cost reports to use the current year's SSI fractions if they were settled using the prior year's SSI fraction before the publication of the current year's SSI fractions.

Response: We appreciate the support for our proposal to change the timing of our match and calculation of the SSI fractions from 6 months after the end of the Federal fiscal year to 15 months after the end of the Federal fiscal year. We believe that our proposal to conduct the SSI eligibility match and calculate the SSI fractions 15 months after the end of the Federal fiscal year will ensure that the SSI fractions are calculated with the best data available to us at that time. We note that the 15-month timeframe proposed is an approximation and subject to the data validation protocols as described previously in this final rule. We believe that the match will be conducted no sooner than 15 months after the end of the Federal fiscal year and the match process, including all appropriate validation steps as finalized, will be performed as efficiently as possible and in accordance with the production cycles of the required data files.

Hospitals submit their cost reports based on their cost reporting period, which varies by hospital. Thus, it would be administratively unwieldy to conduct the SSI match in "real-time" and calculate an individual hospital's SSI fraction whenever that hospital's cost report needed to be settled. By calculating the SSI fractions 15 months after the end of the Federal fiscal year, we believe that we are striking an appropriate balance between the best data available to us at the time and the agency's operational needs, using the best available data that does not unduly hinder the cost report settlement process. As we discussed in the proposed rule, hospital cost reports are submitted to the Medicare contractor no later than 5 months after the end of the provider's cost reporting period. The Medicare contractor must accept the cost report within 30 days of receipt (in accordance with 42 CFR 413.24(f)(2)(i) and 413.24(f)(5)(iii)), and is expected to settle the cost reports that are not audited within 12 months of acceptance of the cost report (in accordance with Medicare Financial Management Manual Publication 100–06, Chapter 8, Section 90). Generally, hospital cost reports are not final settled without the SSI fraction that corresponds to the fiscal year in which the cost report began. Commenters raised concerns that hospitals with fiscal years beginning October 1, 2010 or December 1, 2010 (thus, ending September 30, 2011 or November 30, 2011) would be settled before the release of the SSI fractions. Those cost reports would be submitted by the end of February 2012 or April 2012; they would be accepted by March 2012 or May 2012 and would need to be final settled no later than March 2013 or May 2013. We believe that under our proposal to calculate the SSI match 15 months after the end of the Federal fiscal year, cost reports will be settled with the appropriate SSI fraction within the timeframe of cost report settlement and that cost reports will be final settled with the SSI fraction of the given year. In the case where a cost report is required to be settled before the SSI fractions are published, CMS may instruct that the contractors settle the cost report with the latest SSI fraction available and may reopen the cost report to issue a revised notice of program reimbursement once the appropriate SSI fraction is available, or we may instruct the contractors to wait to settle the cost report until the appropriate SSI fractions are published. We will continue to evaluate what would be the best approach in such a scenario.

Comment: One commenter stated that the chart in the proposed rule that displayed the timeline for the revised match process indicated that, for FY 2011, the timely filing of claims ends in December 2012 when it should be September 2012. The commenter asked that CMS correct the deadline for the timely filing of claims for FY 2011 to read September 2012.

Response: We agree with the commenter. Under section 6404 of the Affordable Care Act, the deadline for timely filing of claims has been revised to be one year after the end of the Federal fiscal year, effective January 1, 2010. Therefore, hospitals will have until September 2012 to file their FY 2011 claims. The chart has been revised in this final rule to reflect this change. Although the deadline for the timely filing of claims is 12 months after the end of the Federal fiscal year, we are finalizing our proposal to conduct the data matching process and calculate SSI fractions approximately 15 months after the end of the Federal fiscal year to ensure we have captured all of the inpatient claims and to capture as many retroactive SSI entitlement determinations as possible.

After consideration of the public comments that we received, we are adopting a policy to conduct the data matching process approximately 15 months after the end of the Federal fiscal year.

5. CMS Ruling 1498–R

On April 28, 2010, the CMS Administrator issued a CMS Ruling, CMS–1498–R (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. As indicated above, we have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the Ruling.

Comment: Several commenters addressed a variety of issues related to the Ruling.

Response: We note that Administrator Rulings are not subject to public comment and that we did not seek public comment on CMS Ruling 1498–R. Accordingly, we are not summarizing or providing responses to comments related to the Ruling in this final rule.

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 the codification of our policy of including 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 final rule (72 FR 47384), we made a technical correction to amend the regulations at § 412.106(b)(2)(i) and § 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.

In the proposed rule, we indicated that we were 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, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24006 and 24007), we proposed to replace the word "or" with the word "including" in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).

Comment: We did not receive any public comments on this specific proposal. However, several commenters urged CMS to reconsider its policy to include Medicare Advantage days and days for which a beneficiary exhausted his or her Medicare inpatient hospital benefits in the SSI fraction. The commenters stated that such days did not represent days that individuals were "entitled to benefits under Medicare [P]art A" (because the patient days were not paid for under Medicare Part A) and as such, should not be included in either the numerator or denominator of the SSI fraction. The commenters stated that, to the extent that dually eligible (that is, simultaneously enrolled in Medicare and Medicaid) Medicare Advantage patients or exhausted benefits patients had an inpatient hospital stay, those days should be included in the Medicaid fraction. Additionally, a commenter stated that CMS did not have sufficient processes in place to assure that the agency is properly counting all of the days in the SSI fraction and "is not double counting any of them in both the numerator of the Medicaid fraction and the denominator of the SSI fraction." The commenter asked that CMS address why it "* * * thinks it need not properly capture all of these days in the denominator of the SSI fraction or the precise steps that CMS has or will take to assure that the agency is capturing all of these days in that denominator."

Response: We did not propose any changes to the categories of Medicare days that we include in the SSI fractions. Specifically, the proposed rule states that "We did not propose any changes with respect to the final step in determining the SSI fraction. As we stated in the proposed rule, to calculate the numerator of the SSI fraction, CMS will 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 will continue to sum a hospital's total Medicare inpatient days in the acute care part of the hospital."

Accordingly, we are not responding to these comments in detail. However, we disagree that Medicare Advantage days and exhausted benefit days should be excluded from the SSI fraction. We believe that the days of all patients who are entitled to SSI and Medicare Part A should be included in the Medicare fraction. We adopted a policy to include

exhausted benefit and other noncovered days in the SSI fraction, after notice and comment rulemaking, in FY 2005 (69 FR 49099). We adopted a policy to include Medicare health maintenance organization (HMO) days in the September 4, 1990 final IPPS rule (55 FR 35994), and this longstanding policy has continued as Medicare HMOs have evolved, and these patient days have been included with every iteration of Medicare HMOs, including patient days for beneficiaries entitled to Medicare Part A but who elect to obtain their benefits through Medicare Advantage. As discussed above, we codified this policy in our regulations in the FY 2005 IPPS final rule (69 FR 49099).

As we have previously explained, we believe that, in the statutory section which sets forth the Medicare DSH fraction, the phrase "entitled to benefits under [P]art A" refers to individuals who are entitled to Part A benefits under Part A pursuant to section 226, section 226A, section 1818, or section 1818A (42 U.S.C. 426, 42 U.S.C. 426–1, 42 U.S.C. 1395i–2, or 42 U.S.C. 1395i–2(a), respectively). We note that the statute uses mandatory language, unambiguously stating that qualifying individuals "shall be entitled to benefits under [P]art A." Patients who have exhausted their Part A hospital benefits or enrolled in Medicare Advantage still meet the statutory criteria for entitlement to Medicare Part A benefits, even though Medicare Part A does not directly pay for a particular inpatient day.

With respect to exhausted benefit days, we note that a beneficiary's right to have Medicare make a payment is subject to the limitations in Part A. The rule that Medicare will not pay for days after Part A hospital benefits are exhausted is an example of one of those restrictions. Thus, a patient remains entitled to benefits under Part A on days where Medicare does not make a payment because of those limitations, and consistent with section 1886(d)(5)(F)(vi)(I) of the Act, these days should be included in the SSI fraction.

With respect to the days of patients enrolled in Medicare Advantage plans, we believe that the sections of the Social Security Act which create Part C clearly demonstrate that Part C enrollees remain entitled to Medicare Part A benefits, and we do not believe that Congress intended to alter the calculation of the DSH payment adjustment when it enacted Medicare Part C. Moreover, we also believe that the commenters' objections to including the days of patients enrolled in Medicare Advantage would be equally applicable to patients enrolled in section 1876 risk plans, but section 1876 of the Act repeatedly makes clear that patients enrolled in section 1876 risk plans remain entitled to benefits under Medicare Part A.

Finally, while the commenters suggest that patients who have exhausted their Part A hospital benefits or enrolled in Medicare Advantage should be counted in the Medicaid fraction, we note that not all patients who are entitled to SSI are also eligible for Medicaid. Thus, adopting the commenters' proposal would result in some patients entitled to SSI and Medicare Part A not being counted in the numerator of either of the DSH fractions. We believe that this result would be contrary to Congressional intent. Consequently, we see no reason to revise our policy at this time.

In response to the comment requesting that CMS assure that it is including all exhausted days and Medicare Advantage days in the SSI fraction and asserting that CMS does not have sufficient processes in place to assure accurate counting, we believe that we are properly counting these types of days, to the extent that hospitals comply with Medicare requirements and submit claims for those days. We do not believe it is necessary to go into further detail about our processes for capturing these types of days in this final rule because we did not make any proposal related to that issue.

We are adopting our proposed revision of § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B) as final, without modification.

G. Medicare-Dependent, Small Rural Hospitals (MDHs) (§ 412.108)

1. Background

Under the IPPS, separate special payment protections are provided to a Medicare-dependent, small rural hospital (MDH). MDHs are paid based on the higher of the Federal rate for their hospital inpatient services or a blended rate based in part on the Federal rate and in part on the MDH's hospital-specific rate. 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 at 42 CFR 412.108 set forth the criteria that a hospital must meet to be classified as an MDH.

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 accurately 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, as specified in the regulations at § 412.108(a)(1)(iii), 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.

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. 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, 226A, 1818, or 1818A of the Act (Entitlement to Hospital Insurance Benefits). In fact, for purposes of determining DSH payment adjustments under the IPPS in accordance with section 1886(d)(5)(F)(vi)(I) of the Act, our policy includes, in the Medicare inpatient count, all individuals entitled to Medicare Part A benefits, including Medicare patients who have exhausted Medicare Part A coverage. This policy is discussed in the FY 2005 IPPS final rule (69 FR 49090 through 49099).

Accordingly, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23999), we proposed 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 (health maintenance organizations (HMOs) and competitive medical plans (CMPs)). We note that, for inpatient care provided to Medicare Part A entitled 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.

Comment: Several commenters supported the proposed change to the MDH policy to include in the count of Medicare inpatient days or discharges individuals entitled to Medicare Part A, not just those receiving Medicare Part A benefits. Another commenter asked if the proposed change in policy would be effective October 1, 2010, applying to MDH status determinations from that date forward, or if the proposed change would be considered a clarification of current policy and, therefore, would apply retroactively.

Response: The MDH proposal to better conform the regulations to the statute by including in the count of Medicare inpatient days or discharges individuals entitled to Medicare Part A even if they are not receiving Part A hospital inpatient benefits because they have exhausted these benefits is a proposed change in policy. Because we are finalizing the proposed change in this final rule, the final policy change will be effective beginning October 1, 2010, at which time all Medicare days or discharges of patients entitled to Medicare Part A will be counted as Medicare days or discharges, affecting the determination of MDH status for hospitals from October 1, 2010 forward.

After consideration of the public comments we received, we are adopting the proposed revision to the Medicare-dependency criterion at § 412.108(a)(1)(iii) as final.

3. Extension of the MDH Program

As we discussed in the June 2, 2010 supplemental proposed rule to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30926), section 3124 of the Affordable Care Act extended the MDH program from the end of FY 2011 (that is, for discharges occurring before October 1, 2011) to the end of FY 2012 (that is, for discharges occurring before October 1, 2012). Under prior law, as specified in section 5003(a) of Public Law 109–171 (DRA 2005), the MDH program was to be in effect through the end of FY 2011 only. Section 3124(a) of the Affordable Care Act amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act to extend the MDH program and payment methodology from the end of FY 2011 to the end of FY 2012, by striking "October 1, 2011" and inserting "October 1, 2012". Section 3124(b) of the Affordable Care Act also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. Section 3124(b)(2) of the Affordable Care Act also amended section 13501(e)(2) of OBRA 1993 to extend the provision permitting hospitals to decline reclassification as an MDH through FY 2012. We proposed to amend the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect these legislative changes.

Comment: One commenter supported the extension of the MDH program for an additional year, through FY 2012.

Response: We appreciate the support of the commenter.

We are adopting as final, without modification, the proposed changes to § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program for an additional year, through FY 2012.

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"

As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24007), 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. (We note that the ACGME is now a separate entity from the American Medical Association. Therefore, in this final rule, we are making a technical amendment to the regulations at § 415.152 to remove the words "of the American 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 also would 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, in the FY 2011 IPPS/LTCH PPS proposed rule, we proposed 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 proposed 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 proposed to make a similar conforming change to the definition of "primary care resident" at § 413.75(b). We proposed that 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.

Comment: Several commenters expressed appreciation for CMS' clarifications regarding which programs are "approved medical residency training programs" and which individuals are residents or physicians. Other commenters indicated CMS' clarification is consistent with their understanding of when an individual is treated as a resident or physician.

Response: We appreciate the commenters' support and understanding of our policy regarding approved medical residency training programs described in the proposed rule.

Comment: Some commenters noted that CMS did not specifically address the applicability of existing Line 70 on Worksheet B, Part I of the Medicare cost report, which historically has been used to report the costs of interns and residents in unapproved programs, nor did CMS discuss the treatment of residents with limited medical licenses. The commenters requested that CMS clarify its position regarding these categories of residents in unapproved programs and hoped that CMS did not intend to eliminate the use of Line 70 of Worksheet B, Part I.

Another commenter noted that CMS clarified that residents and fellows only fall into two categories: (1) Residents and fellows in programs recognized as approved for GME purposes; and (2) residents and fellows in non-approved programs classified as physicians who would bill under the MPFS. The commenter noted that many residents, such as the residents in the transplant surgery program or other advanced but unaccredited training programs, would not fall under either category (1) or category (2) because they are not fully licensed. Another commenter noted that States also have different licensure laws, with some states requiring residents to have temporary licenses, while other States expect residents to be fully licensed by the second or third year of residency after completion of an internship (the first year of training after medical school), and taking Step III of the United States Medical Licensing Examination (USMLE). The commenter added that bylaws in academic medical centers differ, and that the trainees in unapproved programs cannot always bill for services provided because they may not be authorized under their institution's bylaws to do so because they are "in a formal training program."

Response: The commenters are correct that the Medicare cost report does include a line (Line 70 on Worksheets A and B) for hospitals to receive payment for the services provided by residents who are not in approved programs. In the case of programs that are not either accredited or do not count toward board certification, in the September 29, 1989 final rule (54 FR 40295), we explained that:

"Medicare would pay its share of the costs of residents not in approved programs as described in § 405.523 of our regulations regarding residents not in approved teaching programs. Under § 405.523, hospitals are paid under Part B for up to 80 percent of the reasonable costs of services (that is, salaries and salary-related fringe benefits) of interns and residents who are not in approved programs, after payment of the Part B deductible by the Medicare beneficiary. No other educational program costs (that is, faculty compensation costs and other direct and indirect program expenses) in connection with such residents are payable. The Medicare beneficiary incurs the expense of deductible and coinsurance amounts as determined on the basis of the hospital's charges under Part B of the Medicare program."

"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 as physicians' services."

(We note that the regulations that were previously located at § 405.523 are currently located at § 415.202.)

The regulation at § 415.202(a) state, as a general rule, that "For services of a physician employed by a hospital who is authorized to practice only in a hospital setting and for the services of a resident who is not in any approved GME program, payment is made to the hospital on a Part B reasonable cost basis regardless of whether the services are furnished to hospital inpatients or outpatients."

We understand that there are advanced training programs that exist, such as those in transplant surgery and surgical oncology, which are not accredited by the ACGME, nor do they lead to board certification in those subspecialties, yet they are "accredited"

by their respective medical societies. As such, they are formally organized, planned, structured courses of study that are at least one year in duration. We also understand that, although the participants in these advanced training programs have already completed at least one residency, there may be reasons unique to them, their teaching institution, or state as to why these trainees are not always fully licensed. Therefore, we understand that some trainees who are not participating in an "approved medical residency program" are not currently billing under the MPFS for the services they provide in the programs.

We believe Part B reasonable cost payment under § 415.202 may be applicable only in the instance where the trainee is not fully licensed in the State in which he or she is participating in an unapproved program. Services provided by fully licensed physicians, for example, those who are shadowing an experienced senior physician but are not in a formally organized, planned, standard course of study, or who are gaining practice experience, would not be paid under § 415.202. However, we are contemplating future rulemaking that would revise the regulations at § 415.202 to not allow Part B reasonable cost payment for the services of any individuals who have already completed one residency program, regardless of licensure status.

Comment: Some commenters requested that fellowship programs that are approved by the American Society of Transplant Surgeons (ASTS) be considered approved programs for purposes of direct GME and IME payment, even though the ASTS is not listed currently as one of the accrediting agencies at § 413.75(b), nor is there any board certification examination. The commenters noted that the ASTS is a national accrediting body, the programs are "formally organized, standardized, structured courses of study," and residents desiring to complete these programs participate in a formal match through the National Resident Matching Program (NRMP). A commenter also pointed out that training of these fellows occurs in "Medicare approved transplant programs" approved by CMS to receive Medicare payment.

Another commenter asked that CMS clarify the proposed rule to state that an "approved" program can be (1) one that is accredited by a national organization listed at § 415.152 or (2) one that leads to certification by its governing body or toward board certification by the ABMS. The commenter added that as medical training evolves over time, many specialties are not currently part of CMS' "approved" list, even though they are recognized by national organizations, such as the ASTS. Another commenter added that the ACGME's Green Book lists some subspecialty training programs approved by various specialty societies and academies, and that often this level of approval is the first step to becoming eventually accredited by the ACGME. The commenters requested that CMS update and expand the list of "approved" accrediting agencies accordingly.

Response: As we noted above, 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." Our regulations at § 415.152 define an "approved graduate medical education (GME) program" to include a residency program approved by one of the accrediting bodies identified at section 1861(b)(6) of the Act, or "a program otherwise recognized as an 'approved medical residency program' under § 413.75(b)" of our regulations. Section 1861(b)(6) of the Act lists only four accrediting bodies—the Council on Medical Education of the American Medical Association (now the ACGME), the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association (now the AOA), the Council on Dental Education of the American Dental Association (now known as CODA), and the Council on Podiatric Medical Education of the American Podiatric Association. The ASTS is not listed in the Act. We cannot update or expand this list without a change in the law. In addition, the regulation at § 413.75(b) defines an "approved medical residency program" as one that is either approved by one of the four national organizations noted above or one that "may count towards certification of the participant in a specialty or subspecialty listed in the current edition" of either the AMA or the ABMS directory. Because there is no board certification examination specifically for these transplant and other advanced training programs, they cannot be recognized as approved medical residency training programs for purposes of receiving direct GME and IME payments under Medicare under our current regulations.

Comment: One commenter asked for clarification regarding participants in programs that are accredited by the ACGME and lead to receipt of a Certificate of Additional Qualifications (CAQs) from a specialty board. The commenter indicated that the participants in these programs, often referred to as "fellows," already received board certification in the initial specialty. The commenter requested assurance that these fellows can still be counted as residents for GME purposes, even though they are not required to sit for an additional board examination, and indicated that completion of the fellowship is sufficient for receipt of the CAQ.

Response: As we noted previously, there are numerous subspecialty programs that the ACGME accredits. Because these programs are accredited by the ACGME, which is one of the accrediting bodies specified at section 1861(b)(6) of the Act and the regulations at § 415.152 for an approved medical residency training program, the participants in the program are considered to be residents for IME and direct GME payment purposes, even though they have already received an initial board certification.

Comment: One commenter requested that CMS more clearly define what constitutes a "fellowship" for the direct GME and IME FTE counts. Another commenter also requested clarification regarding fellows, stating that there are four types of fellows: (1) Fellows in formal programs that qualify as Medicare approved programs; (2) fellows in formal programs that qualify as nonapproved programs; (3) junior faculty with a dual appointment as a fellow but who are not in a formal program at all; and (4) fellows solely engaged in research outside the scope of an approved program. The commenter stated that most major academic medical center bylaws distinguish between these individuals based on whether they have patient billing privileges. The commenter believed that the last two cited categories of fellows should be categorized as physicians, not residents.

Response: The existing regulations at § 413.75(b) define "resident" as 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. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24009), we proposed 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." In both the existing and proposed revised

definitions, a "resident" is defined to include interns, fellows, and residents. In other words, regardless of the term used by the academic medical community, as long as the individual is participating in an "approved medical residency program," the "fellow" is considered to be a "resident" for Medicare IME and direct GME payment purposes.

To respond to the commenter that mentioned the four categories of fellows, as we have explained in response to other comments, we do not agree that "fellows" in formal but nonapproved programs, such as those recognized by specialty medical societies, should be categorized as residents for IME and direct GME purposes. However, we do agree with the commenter that junior faculty not in an approved or any training program, whether approved or nonapproved, and fellows engaged in research that is outside the scope of any approved residency program, should not be categorized as residents.

Comment: One commenter disagreed with the statement in the proposed rule that additional training in the same specialty or subspecialty should not be counted for IME and direct GME payment purposes. The commenter believed that this type of training should be included if a board considers such training necessary to be admitted to the board. The commenter asserted that qualifying for an examination is based on skill level, rather than only completion of time requirements, and that most boards rely on the residency program director's attestation about the individual physician's readiness. For example, after a physician completes the minimum years of training, the program director may require additional formal training in one or more subspecialties to raise the resident's skill level. The commenter noted that there is no rule that a candidate must apply for admission to an examination after he or she completes the minimum training required, and that the boards consider quality, not quantity, which can include a broad range of formal training.

Response: As we stated in the proposed rule, in instances where an individual has already completed a residency program, and is continuing to participate in additional training, in order to decide whether an individual is considered a resident or a physician for purposes of Medicare payment, the pertinent considerations are: (1) Whether the individual actually *needs* the training in order to meet the generally applicable board certification requirements in *that* specialty; *and* (2) whether the individual is formally participating and enrolled in an organized, standardized, structured course of study. The commenter believed that additional training in the same specialty or subspecialty should be considered part of an approved program for IME and direct GME payment purposes if a board considers such training necessary for the individual to be admitted to the board. However, we do not agree that training in the specialty or subspecialty that is not part of the generally applicable requirements for board certification, but is supplemental training to raise the skill level of a particular individual, is considered to be participation in an approved program as required in order to become certified. The ACGME and the ABMS establish *minimum, generally applicable* standards for successful completion of training and qualifications for board certification. While certain individuals may need to pursue additional supplemental training in order to ensure their personal skill levels are sufficient prior to pursuing actual board certification, we do not believe such training would be part of the generally applicable requirements for taking a board examination. The ACGME and the ABMS are national organizations that establish and apply these minimum standards nationally across all programs, and not on a resident-by-resident basis. 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" (emphasis added). "As required" means nationally applicable standards, not requirements that are determined on an individual, case-by-case basis. Medicare is also a national program. It would be highly impractical for hospital administrators and the Medicare contractors to determine whether each individual trainee (particularly in large teaching hospitals where there could be many such individuals) is participating in training that may or may not be considered necessary for board certification for that specific individual.

Accordingly, we believe that training that is only intended to enhance an individual's skills beyond the minimum required level is not part of an approved medical residency program. While it is true that there is no rule that a candidate must apply for a board examination immediately after he or she completes the minimum amount of training, the completion of additional training is not part of the generally applicable requirements for the board examination. Therefore, an individual who undertakes such additional training is not considered a resident for IME and direct GME payment purposes.

We recognize that a board may look favorably upon an individual's additional training beyond the minimum requirements in the process of considering a particular individual for certification. While we understand that there could be some degree of personalized consideration when an individual applies to sit for a board examination, as stated in response to the previous comment, this does not mean that all of the training that the individual has completed is actually required. It could be true that, in certain cases, completion of the minimum training requirements does not guarantee admittance to a board examination. However, because the boards set forth national standards, in most cases, the minimum training requirements are sufficient. Further, we are not convinced that additional GME payments should be made with respect to trainees who choose a customized approach to their training (that is, one that differs from their colleagues in the same program), extending that training beyond the minimum requirements established by the ACGME and the ABMS. At the point where a trainee has completed the national standard minimum requirements for certification, and chooses to pursue additional training that is not generally required for board certification in that specialty, that individual should no longer be considered a resident for IME and direct GME purposes.

Comment: One commenter believed that the proposed revision to § 413.75(b) that seeks to clarify which trainees are allowable for Medicare GME payment by including the terms "formally accepted, enrolled, and participating in" to the definition of a "resident" needs to be more comprehensive and more focused. The commenter stated that codifying that an approved program must be formally organized does not help to resolve questions regarding unaccredited programs, particularly for "services of residents not in approved GME programs" (42 CFR 415.202) or attending or junior attending physicians participating in informal training or "nontraining." The commenter suggested that expansing the definition of an "approved program" would be more appropriate than expanding the definition of a "resident." According to the commenter, the main issue is "formal unaccredited programs," and "it

would be more helpful to define what they are rather than focus on a few obvious examples of what they are not." The commenter suggested the following expanded definition of an "approved residency program" that "may count toward certification of the participant in a specialty or subspecialty" (42 CFR 413.75(b)): "A training program that 'may count toward certification' would be one that is a formally organized unaccredited program and may be counted by individual ABMS boards when accepting a candidate's admission to a board certification examination. Allowable training includes training considered by an individual board's application process."

The commenter also referred to the original conference language accompanying the original Medicare legislation. The commenter quoted the following: "Medicare shares in the hospital's training cost because it increases the quality of care in the institution" (Senate Finance Committee Report 89–404, June 30, 1965). The commenter was concerned that the proposed rule discussion appears to state that Medicare will not share in the hospital's medical education costs for an individual training beyond the minimum requirements, but rather treat these costs as nonhospital costs to be paid under the MPFS. Yet, the commenter added, section 1832(a)(2) of the Act clearly states that residents are not paid as physicians. The distinction is that resident services are hospital costs because training involves a group of patients, whereas physicians' services are billed professional fees for services to a specific patient. The commenter did not believe that it was the Congressional intent to change training activities of residents once they completed minimum accredited specialty and subspecialty requirements.

Response: We disagree with the commenter's assertion that our proposed revised definition of "resident" at § 413.75(b) is not sufficiently comprehensive or focused. Rather, we believe our proposed revised definition of "resident" correctly characterizes what a resident is for IME and direct GME payment purposes. We do not believe that residents not in approved programs (as discussed at § 415.202) should be counted as residents for IME and direct GME payment purposes. Perhaps the commenter is confused because "resident" is defined in two places in the regulations, first at § 413.75(b) for purposes of direct GME and IME payment, and second at § 415.152 for purposes of payment for physician services in teaching settings. Furthermore, we do not believe that attending and junior attending physicians participating in informal training or nontraining should be counted as residents for IME and direct GME payment purposes either. We believe that formal unaccredited programs are easy to identify, in that they are not accredited by the ACGME or AOA. If there is no explicit board certification for these programs, the participants in these programs cannot be counted for IME and direct GME payment purposes. Therefore, we do not agree with the commenter's recommended expanded definition of "approved residency program."

With regard to the commenter's reference to section 1832(a)(2) of the Act, section 1832 addresses the scope of benefits for which payment is made under Medicare Part B, including physician services. Section 1832(a)(2) specifically addresses services other than inpatient hospital services furnished by or under arrangements with a provider of services by residents of a hospital. We do not believe this refers to individuals who are licensed (in other words, those are physicians as defined at section 1861(r) of the Act) and are not in approved programs. Therefore, because the individuals are licensed and are not in approved programs, we believe they should be billing for their services under the MPFS. If an individual is in an approved program, he or she is a resident for purposes of a hospital's IME and direct GME FTE count. Further, although the commenter is correct that Congress did not limit Medicare direct GME payment or IME payment to training only occurring within the initial residency period, the ACGME and the ABMS have established minimum standards required for successful completion of a particular specialty or subspecialty. If a physician is involved in training that is not part of the established requirements, payment for the services provided by that physician should be made under the MPFS, not as part of direct GME or IME. Further, we note that it is specious for the commenter to assert that it was not "Congressional intent to change training activities of residents once they completed minimum accredited specialty and subspecialty requirements." In fact, as expressed in the conference report accompanying the original Medicare legislation, funding for GME activities was intended to be time limited. Specifically, the conference report stated, "Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other way,* that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program" (emphasis added) (S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)). Accordingly, we believe that Medicare GME funding for trainees should be "time limited" and not be made in perpetuity for trainees that are not in an approved medical residency training program or for whom the training is not required in order to meet the standard requirements for board certification.

Comment: One commenter read the proposed rule discussion to suggest that if all training must be necessary to meet board certification, formal training beyond the minimum amount specified in the board certification requirements should not be included for GME payment purposes. The commenter believed this statement contradicts policy expressed in the September 29, 1989 **Federal Register** (54 FR 40306), which states, "If it is clear that these individuals are actually in formally approved programs, we believe that they should be counted as residents in approved programs even if the individual has completed the requirements for board certification." The commenter believed that chief residents are enrolled in accredited programs and are eligible for inclusion in the IME and direct GME FTE counts, even though certain chief residencies extend beyond the minimum accredited length of the program. The commenter also noted that there are several instances, particularly in prestigious teaching institutions, where the ACGME allows a hospital to offer a program length that is longer than the typical minimum accredited length for that specialty. For example, a hospital may choose to operate a 6- or 7-year (as opposed to the usual 5-year) surgery program, wherein accreditation accrues to the entire program, candidates compete for slots through the National Residency Match Program, and sign formal contracts upon entering these programs. The commenter referred to a letter from CMS (then HCFA) written in 1996 that acknowledged that, in some cases, a university's formal program may be longer than the ACGME's published accreditation length, and stated that the school length, rather than the accreditation length, would apply. The commenter urged CMS to clarify

that training beyond the accredited length of a formally organized program is included in the IME and direct GME FTE resident counts.

Response: We made the statement in the September 29, 1989 **Federal Register** (54 FR 40305) that was referenced by the commenter in response to a comment we received from representatives of the specialties of internal medicine and family practice who requested clarification of the status of individuals who are spending a fourth year in internal medicine or family practice (both 3-year programs). The commenters noted that some programs add a fourth year for a variety of reasons, and in some instances, "individuals who have completed their requirements for board certification spend a fourth year as a chief resident and are technically no longer in a program leading to certification in a specialty or subspecialty" (54 FR 40305). Our response was as follows:

"If it is clear that these individuals are actually in formally approved programs, we believe that they should be counted as residents in approved programs even if the individual has completed the requirements for board certification. The situation is not unlike those we discussed in the proposed rule concerning Transitional Year programs and General Dentistry programs, neither of which, in itself, lead to certification in a specialty or subspecialty. We do not believe that Congress enacted section 1886(h) of the Act to reduce the types of programs recognized by Medicare. Thus, if the ACGME and other accrediting bodies recognize such individuals as residents in the General Internal Medicine or Family Practice program, we would count them for purposes of direct GME payment at .5 or 1.0 FTE depending on whether they are still in their initial residency period. We would differentiate these individuals from those who have completed their residency but remain for an additional period of time with the academic settings to continue their training outside the context of a formally organized approved program. Individuals in the latter group should be paid as physicians." (54 FR 40305 and 40306)

We recently consulted with the ACGME to determine what its policy is regarding individuals, such as "chief residents," that, in certain programs, stay beyond the minimum accredited length of the program. We learned that in the surgical specialties and a few of the other hospital-based specialties, all fifth year (or final year of training) residents are considered "chief resident," or in their chief resident year. This is the final year of the ACGME-accredited program. Therefore, we consider "chief residents" in surgery programs to be residents for IME and direct GME payment purposes. However, we learned from the ACGME that in internal medicine and pediatrics, acting as a "chief resident" is not a requirement. There are only a select few "chief residents" per program, and the chief residency is completed *after* the final year of the ACGME-accredited residency. According to the ACGME, it is *not* part of the accredited training. Therefore, although our policy in the September 29, 1989 **Federal Register** allowed chief residency years that were completed after the minimum requirements for board certification have been met to be considered part of an approved program for IME and direct GME payment purposes, effective for cost reporting periods beginning on or after October 1, 2010, we are revising our policy regarding chief residencies that occur after the accredited program is completed and when minimum requirements for board certification are already satisfied. That is, individuals that act as chief residents after they have completed the accredited program and have satisfied minimum requirements for board certification are no longer considered residents for IME and direct GME payment purposes. (We understand they would be considered junior faculty in many teaching hospitals.) This is consistent with our policy as expressed in the proposed rule, which states that in order to decide whether an individual is considered a resident or a physician for purposes of Medicare payment, the pertinent questions are (1) whether the individual actually *needs* the training in order to meet board certification requirements in *that* specialty; *and* (2) whether the individual is formally enrolled and participating in an organized, standardized, structured course of study. Because the chief residents in internal medicine and pediatrics do not need the training in order to meet board certification requirements, effective for cost reporting periods beginning on or after October, 1, 2010, we are not considering them to be residents for IME and direct GME payment purposes.

With regard to the comment asserting that the ACGME allows a hospital to offer a program length that is longer than the typical minimum accredited length for that specialty, and that accreditation accrues to the entire program, we consulted with the ACGME on this point as well. We were informed that this additional time is *not* part of the accredited program, nor is the ACGME aware of when the situations described by the commenter occur. Therefore, individuals training in a hospital's program that extend beyond the actual accredited length are *not* considered residents for IME and direct GME payment purposes because they are no longer training in an accredited program according to the ACGME. Thus, for example, an individual training in a 6- or 7-year general surgery program would only be counted as a resident for IME and direct GME purposes in PGYs 1 through 5. The commenter references a letter that CMS (then HCFA) wrote in 1996 that addresses this point of hospitals that operate programs that extend beyond the minimum accredited length. CMS was asked "What are the criteria for determining [sic] approved program length for IME?" We responded, in part, as follows:

"* * * we do believe the length of an approved program may be of relevance in the intermediary's IME determination. The question then is, what is to be considered the program's recognized length? In your letter, you stated that BCCA's (Blue Cross of California) position is that 'the approved program length is the ACGME published accreditation length for the specific university.' We generally agree with this position. However, we acknowledge that the ACGME published accreditation length may reflect only the minimum number of years and that in some cases, the university's formal program may be longer. For the intermediary to recognize a program length that is longer than that published by the ACGME, the intermediary should expect to see that a majority of residents are in the program for the same length of time. This establishes a base by which aberrancies can be identified. There may be a legitimate reason for a full-time resident to be formally enrolled in an approved program for a length of time that is greater than the norm, but, again, this would need to be explained and documented by the provider. If residents are serving as fellows or chief residents, they must be doing so under an approved program to be counted."

In this response above, we were allowing participants in a program that extends beyond the minimum accredited length to be counted as residents for IME (and direct GME) purposes if the hospital could document to the intermediary that the majority of participants were training in the program for the same length of time. However, based on what we have recently learned from the ACGME, this position expressed in the 1996 letter is *not* consistent with the ACGME's policy. That is, the time spent in a

program beyond the minimum accredited length is not recognized by the ACGME, even if the majority of the participants in the program are training beyond the accredited length for the same length of time. Accordingly, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy regarding programs that hospitals operate for longer than the accredited (that is, the minimum) length. That is, individuals training in a program that extends beyond the actual accredited length are *not* considered residents for IME and direct GME payment purposes for the period of time extending beyond the minimum accredited length, because they are no longer training in an accredited program according to the ACGME.

Comment: One commenter recommended that CMS adopt a policy that in order for a program to be approved, it should be at least a year in length. The commenter believed that this would distinguish formal programs from shorter continuing medical education and inservice training of physicians.

Response: We are sympathetic to the commenter's recommendation because it seems consistent with our existing policy regarding what an approved, formal, structured program is. As we indicated in the proposed rule, 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). However, we do not believe we need to change the regulations text to specify that an approved program must be "at least 1 year in length" because we believe that programs that meet the definition of "approved" are 1 year in length. We may consider this recommendation for future rulemaking if we find that it is necessary.

Comment: One commenter indicated that from its experience, certifying boards do allow unaccredited training as part of the required training, and the boards may not want to provide specific statements regarding the types of allowable unaccredited training in order to maintain flexibility in the requirements. The commenter mentioned that the requirements listed by the American Board of Radiology for certification in vascular and interventional radiology include one year of training in an ACGME accredited subspecialty program and "one year of practice or additional training (one-third of that time) in the subspecialty." Accordingly, the commenter stated that a hospital may only be able to document that unaccredited training was accepted by a board after a resident achieved certification.

Response: A distinction should be made between training that an individual pursues that is *in addition to* the minimum standards required for completion of the accredited program and for board certification, and unaccredited training that is actually required for board certification. As we stated in response to a previous comment, while we understand that there could be some degree of personalized consideration when an individual applies to sit for a board examination, this does not mean that *all* of the training that the individual has completed is actually required. Accordingly, GME payments should not be made with respect to training that extends beyond the minimum requirements. With regard to unaccredited training that is actually required for board certification, we understand that, in certain cases, a board may accept unaccredited training as fulfilling part of the requirements for certification. However, the board would not typically accept only unaccredited training, nor would a hospital or trainee know with certainty whether a particular "training" experience will ultimately be accepted, if, as the commenter mentioned (as in the case of vascular and interventional radiology), often the training, and its content and quality, must be verified by the program director and then reviewed by the board. Further, we do not believe it is prudent or practical to wait until after an individual's training was accepted by a board to know if that individual should be included in the IME and direct GME resident counts. To encourage simplicity in administering a national program, it is not unreasonable for CMS to establish guidelines for determining whether an individual should be included in the FTE count. Therefore, in the absence of accreditation and foreknowledge as to whether unaccredited training would be accepted by a board, it is simpler and more practical for such an individual to be categorized as a physician, not a resident, even if the particular "training" is ultimately accepted by the board.

In the case of vascular and interventional radiology subspecialty programs, the American Board of Radiology (ABR) states that the requirements for board certification in vascular and interventional radiology are (in part) as follows: "You must successfully complete one year of fellowship training (after residency) in a vascular and interventional radiology program accredited by the ACGME or by the RCPSC (Canada). You must also complete one year of practice or additional *approved* training, with one-third of that year spent in vascular and interventional radiology" (emphasis added). (*http://www.theabr.org/ic/ic_vir/ic_vir_req.html*). The commenter excluded the word "approved" from its comment. We have spoken with the ABR and learned that "approved" means some kind of one year experience (July to June) that the ABR would approve, not before the training begins, but during or toward the end of the training year, when the individual registers with the ABR in order to schedule the examination in vascular and interventional radiology. Again, we believe that when it is not known with certainty at the time an individual begins a course of "training" whether the board will ultimately accept that training, that experience should *not* be counted as a residency for IME and direct GME payment purposes.

A clear example of time that may be counted toward board certification but certainly should *not* be considered residency training for inclusion in the IME and direct GME resident counts is practice experience. Regarding the time spent in "one year of practice," while the ABR clearly accepts such time as counting toward certification, we do not believe that during that time in which the individual is "practicing" that he or she is considered a resident, particularly not for IME and direct GME payment purposes. It is appropriate for an individual who is practicing to be billing under the MPFS. With regard to the DIRECT pathway (*http://www.theabr.org/ic/ic_vir/ic_vir_direct.html*), which is another method of attaining board certification in vascular and interventional radiology, PGYs 1 through 6 are training years that are accredited by the ACGME. Therefore, the trainee can be considered a resident during those 6 years. However, PGY7 is 12 months of clinical practice, and an individual would be considered a physician during this year and should bill under the MPFS accordingly.

Comment: One commenter urged CMS to work with the ABMS to identify unaccredited training programs that the certifying boards accept toward meeting the requirements for board certification, so as to establish more clearcut guidelines for hospitals to use to

identify which programs would be considered residencies for GME payment purposes under Medicare.

Response: We believe it is important to consult with the accrediting and certifying agencies to ensure that our policies are consistent with theirs, and we welcome communication with them now and in the future. However, for the purpose of this final rule, we are providing clear policy guidance to hospitals and Medicare contractors for purposes of determining whether an individual should be treated as a resident or a physician. Essentially, a resident for IME and direct GME payment purposes is an individual who, in accordance with our revised definition of "resident" at § 413.75(b), 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. The program would be "approved" if it is either accredited by one of the four recognized accrediting bodies, or if not accredited, the individual may be counted as a "resident" if the individual actually *needs* the training in order to meet the standard board certification requirements established for *that* specialty.

Comment: One commenter noted that, in addition to clarifying whether an individual is a resident or a physician, CMS proposed to revise the definitions of "resident" and "primary care resident" effective for cost reporting periods beginning on or after October 1, 2010. The commenter asked whether these definitions reflect a clarification of existing policy, or, as the existence of a prospective effective date suggests, a change in policy. If it is a change in policy, the commenter asked what criteria should be applied for periods prior to October 1, 2010, in determining whether an individual is a resident because some contractors have been using criteria similar to those described in the proposed rule's preamble to determine which individuals should be included in the IME and direct GME FTE counts.

Response: In the recent past, we had been made aware of a situation at a hospital where graduates of allopathic medical schools were training in programs that were accredited by the AOA. The AOA has had a longstanding policy that only graduates of osteopathic schools may enroll and participate in osteopathic residency programs; graduates of allopathic medical schools may not be accepted and train in osteopathic programs. Nevertheless, despite this rule, a hospital did train allopathic individuals in an osteopathic accredited program and sought to count those allopathic FTEs in the IME and direct GME counts. Because the hospital was able to show that at least one of those allopathic individuals was able to use the osteopathic training toward fulfillment of the allopathic board's requirements (and, in fact, successfully achieved allopathic board certification), the hospital argued that although the allopathic individuals were not formally enrolled in the AOA accredited program (since doing so was against AOA policy), the training did count toward board certification, as evidenced by the one trainee who did successfully sit for the allopathic board. Therefore, the hospital added, the training of these allopathic individuals in the osteopathic program was sufficient for *all* the allopathic individuals in the osteopathic program to be counted as residents for IME and direct GME purposes.

Because the existing definition of "resident" at § 413.75(b) states, "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*" (emphasis added), we were persuaded to allow the hospital to count as residents those allopathic individuals who trained in the AOA accredited program. We were persuaded because those individuals arguably did "participate" in an otherwise AOA-approved medical residency program as required "in order to become certified by the appropriate specialty board." (We understand that the hospital has since stopped training allopathic graduates in the osteopathic accredited program.) We note that, in part, the statutory and regulatory intent behind the definitions of "approved medical residency training program" and "resident" is to protect the "approved" status of training in typical accredited programs for residents who may participate in the formal program but, on rare occasions, may not complete their course of training. We do not believe the definitions were intended to include a program such as the particular hospital's program, which, from its inception, in its entirety, was not accredited by the AOA, and where only on rare occasions did participation in the osteopathic program count towards certification in an ACGME accredited program. However, the previous regulation could be read differently such that if even one trainee went on to become board certified on the basis of that training, all participants in that program could be counted as residents for IME and direct GME payment purposes. We believe that it is appropriate to close the loopholes that, for example, had previously allowed the allopathic graduates to be counted as residents while inappropriately training in an AOA program by clarifying that a resident must actually be formally enrolled and participating in an approved medical residency program. Therefore, we proposed to make a prospective change to the definition of "resident," effective for cost reporting periods beginning on or after October 1, 2010, to emphasize that it is *not* sufficient for an individual to merely "participate" in an otherwise approved medical residency program which may ultimately be counted toward board eligibility for his or her own certification, or the certification of any of the other trainees in the program. Rather, under the proposed revised definition of "resident" and "primary care resident" which we are finalizing in this final rule, the individual must be "*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 believe this addition to the definition of "resident" that the individual must be formally accepted and enrolled in the program also will further ensure that junior faculty or other advanced trainees who merely "participate" in some training but are not actually formally accepted and enrolled in the program are not counted as FTEs for IME and direct GME purposes.

To respond to the commenter's specific question as to what criteria should be applied for periods prior to October 1, 2010, in determining whether an individual is a resident, because some contractors have been using criteria similar to those described in the preamble of the proposed rule to determine which individuals should be included in the IME and direct GME FTE counts, we believe that prior to October 1, 2010, the existing regulations text would be controlling. Thus, much of the policy prior to and after October 1, 2010, is the same. However, as explained in response to a previous comment, we are changing our policy with respect to chief residencies and to programs that hospitals operate that extend beyond the accredited length. Prior to cost reporting periods beginning on or after October 1, 2010, according to the September 29, 1989 **Federal Register** (54 FR 40305), if it is clear that chief residents are actually in formally organized approved programs, they

could be counted as residents even if they have completed the requirements for board certification. However, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy regarding chief residencies that occur after the accredited program is completed and when minimum requirements for board certification are already satisfied. That is, individuals that act as chief residents after they have completed the accredited program and have satisfied minimum requirements for board certification are not considered residents for IME and direct GME payment purposes.

With regard to programs that are offered for longer than the minimum accredited length for that specialty, prior to cost reporting periods beginning on or after October 1, 2010, we are allowing participants in a program that extends beyond the minimum accredited length to be counted as residents for IME and direct GME purposes if the hospital could document to the fiscal intermediary or MAC that the majority of participants were training in the program for the same length of time. However, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy regarding programs that hospitals extend beyond the minimum accredited program length for the specialty. That is, individuals training in a program that extends beyond the actual accredited length are *not* considered residents for IME and direct GME purposes for the time extending beyond the minimum accredited length because such training is not part of the accredited program according to the ACGME. We would expect that an individual who has trained in an accredited program for the number of years for which the program is accredited (for example, in a surgery program, this would be 5 years) would have satisfied the minimum requirements for board certification in that specialty.

Comment: One commenter listed several examples of specialties where the boards for those specialties require unaccredited training for certification. The commenter pointed out that, in addition to some subspecialties of radiology, the American Board of Pathology used to require a "credentialing" year in addition to ACGME-accredited training in pathology. In addition, in the late 1990s, the American Board of Pediatrics offered several new certificates in subspecialties such as Adolescent Medicine, Pediatric Emergency Medicine, Developmental-Behavioral Pediatrics, although ACGME accreditation for these subspecialties did not yet exist at that time. Between 2005 to 2009, the Board of Psychology and Neurology allowed a "grandfathering period" for certain fellows who did not participate in ACGME-accredited vascular neurology programs since 2003. Subspecialties of obstetrics and gynecology are currently not accredited by the ACGME, but it is well known that board certificates are available from the American Board of Obstetrics and Gynecology for these subspecialties. The commenter listed other examples of unaccredited training accepted by various boards, with the point being that CMS should allow participants in these programs to be counted in the IME and direct GME FTE counts.

Response: We understand that, historically, it was not unusual for a particular board to begin offering certificates in a subspecialty prior to the ACGME's establishment of accreditation standards for those programs. Training in a specialized area may go on for several years before it is recognized by ACGME as an accredited sub-specialty. We understand that the certifying boards, in certain instances, allow for individuals who have received applicable training prior to the existence of board certification in a subspecialty to be "grandfathered" and receive a board certificate even though there was no board examination in existence yet at the time of the individual's training, and the training was not accredited by ACGME. However, this practice varies by board and subspecialty; there is no uniform policy. Regardless, for Medicare IME and direct GME purposes, if *at the time of the individual's training,* there did *not* exist either ACGME accreditation or a specific board certificate in that subspecialty, those individuals could not be considered residents during their training, nor could a hospital subsequently request reopening of its contemporaneous cost reports to include those individuals in the FTE count after the fact once board certification or ACGME accreditation becomes available for that program. As we stated above, *in the absence of accreditation and foreknowledge* as to whether unaccredited training would be accepted by a board, the individual should be categorized as a resident for IME and direct GME purposes, even if the particular "training" is ultimately accepted by the board.

With respect to subspecialties of obstetrics and gynecology, those subspecialties continue to not be accredited by the ACGME. It is widely known that the American Board of Obstetrics and Gynecology independently recognizes and offers certification to participants in those subspecialties. We believe that trainees in subspecialties of obstetrics and gynecology for which an explicit board certification is offered are considered residents, in accordance with the definition of "approved medical residency training program" at § 413.75(b).

We received some comments that were not within the scope of the proposals, such as funding for second year pharmacy residencies and what constitutes a new medical residency training program. We are not responding to these comments at this time.

After consideration of the public comments we received, we are adopting as final, with some modification, our proposed revisions. Specifically, we are clarifying 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, may not be counted for IME and direct GME payment purposes. Such individuals should be treated as physicians (assuming full licensure) and their services billed to Medicare for payment as physicians' services. If an individual has already successfully completed at least one residency program and has met the generally applicable 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 another different subspecialty, the individual will be treated and bill for services provided as a physician (assuming full licensure). We are making a technical change to the definition of "approved medical residency program" under § 415.152 relating to payment for physician services in teaching settings. We also are revising 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 making 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." These change in the definitions of "resident" and "primary care resident" are effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010. Essentially, a resident for IME and direct GME purposes is an individual who, in accordance with our revised definition of "resident" at § 413.75(b), 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. The program would be an "approved program" if it is either accredited by one of the four recognized accrediting bodies, or if not accredited, the individual who is formally accepted, enrolled, and participating in the program actually needs the training in order to meet the established minimum standards for board certification requirements in *that* specialty.

With regard to chief residencies, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy to provide that individuals that act as chief residents after they have completed the accredited program and have satisfied minimum requirements for board certification are not considered residents for IME and direct GME payment purposes. With regard to programs that are extended by a hospital for longer than the minimum accredited length for that specialty, effective for cost reporting periods beginning on or after October 1, 2010, we are changing our policy to provide that such training is not part of an approved program. That is, individuals training in a program that extends beyond the actual accredited program length are *not* considered residents for IME and direct GME purposes because they are no longer training in an accredited program according to the ACGME.

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 the Medicare GME affiliated group. Under the 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 their 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 (1) If 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); or (2) if 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 are jointly listed as the sponsor 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, if the 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 July 1, 2009–June 30, 2010, each 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.

As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule, 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. 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 the environment and paperwork reduction have prompted us to reconsider our procedure for hospitals to submit Medicare GME affiliation agreements to the CMS Central Office. Accordingly, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24008) we proposed to change our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. We indicated that 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 proposed 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 proposed that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Portable Document Format (PDF) version of that hard copy agreement or in another electronic format that cannot be subject to manipulation. This requirement will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75.

Comment: Commenters supported the proposal for the electronic submission process for affiliation agreements and stated that it would help reduce hospitals' administrative burdens. Many commenters also stated that the proposed electronic process was a logical and more administratively simple method of submitting affiliation agreements. Several commenters suggested that CMS provide hospitals with documentation of the agency's receipt of the electronic submissions of their affiliation agreements, due to the time sensitive nature of this policy.

Response: We appreciate these commenters' support for the proposed process. As we begin the development of the electronic submission system for affiliation agreements, we intend to include a mechanism within that system for acknowledging receipt of the agreements to hospitals upon the

submission of their agreements, as the commenters suggested.

Comment: One commenter praised CMS' efforts to ease the paperwork burden for hospitals, but also claimed that the proposal was not far-reaching enough toward that end. The commenter requested that CMS establish an electronic submission process that was easy to use and that fiscal intermediaries and MACs are required to use to receive affiliation agreements as well. The commenter also recommended that CMS ease the Medicare GME affiliation agreement criteria in general and allow affiliation agreements to become effective as of the date that the agreement is filed with the CMS Central Office.

Response: We appreciate these comments, and we will take them into consideration for the future as we plan to implement the electronic submission system that will accept affiliation agreements. One of the goals in planning the development of the system is to make the system user-friendly as possible.

The comments that we received regarding the criteria for affiliation agreements are not within the scope of the proposed rule. Therefore we are not addressing them in this final rule. We did not propose to make any additional changes to our policies regarding Medicare GME affiliation agreements for FY 2011.

After consideration of the public comments we received, we are finalizing our proposed policy for accepting electronic submission of Medicare GME affiliation agreements. We believe that allowing the electronic submission of affiliation agreements to the CMS Central Office will assist CMS 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 will minimize the paperwork burden for hospitals.

We are currently in the process of developing the electronic submission system for Medicare GME affiliation agreements. If a system is developed that is ready to receive affiliation agreements for the academic year beginning July 1, 2011, we will notify teaching hospitals by May 2011 of the electronic submission process in order to allow ample time for the preparation and electronic submission of affiliation agreements before the July 1, 2011 deadline. We will continue to accept hard copies of affiliation agreements even if the electronic submission system is in operation for the academic year beginning July 1, 2011. Hard copies of affiliation agreements should continue to be sent to: Director, Division of Acute Care, Centers for Medicare and Medicaid Services, Attn: Tzvi Hefter, Mailstop C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244.

4. Technical Correction to the Regulations Relating to the Cost of Approved Nursing and Allied Health Education Activities

Medicare has historically paid providers for the program's share of the costs that providers incur in connection with approved educational activities, which can be divided into three categories: (1) The costs of approved GME programs in medicine, osteopathy, dentistry and podiatry; (2) approved nursing and allied health education activities operated by a provider; and (3) all other costs that can be categorized as educational programs and activities that are considered to be part of normal operating costs. Existing regulations on nursing and allied health education program costs are located at § 413.85. Costs of approved nursing and allied health education programs that are operated by a provider are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of the payment rates for hospitals paid under the IPPS or in the calculation of the payments to hospitals and hospital units excluded from the IPPS. These costs are separately identified and "passed through" (that is, paid separately on a reasonable cost basis).

We recently discovered that a passage in the January 12, 2001 Nursing and Allied Health Education final rule (66 FR 3371) incorrectly states that pass-through payment for the time students train in hospital outpatient departments is not allowed. That is, the passage incorrectly indicates that pass-through payment is only allowed for training while providing care directly to hospital inpatients. The regulations in two places at § 413.85 also incorrectly limit the allowable costs to the inpatient areas of the hospital as follows: (1) "Approved educational activities" are defined at § 413.85(c)(2), in part, as programs that "Enhance the quality of *inpatient* care at the provider," (emphasis added); and (2) under the general payment rules at § 413.85(d)(1)(i)(C), payment for the net costs of nursing and allied health education activities is determined on a reasonable cost basis, if, in part, the approved medical education activity "Enhances the quality of *inpatient* care at the provider" (emphasis added). However, we note that the Provider Reimbursement Manual, Part 1, section 402.1.A, states that the "approved educational activity" must be "designed to enhance the quality of *health care in the institution* or to improve the administration of the institution" (emphasis added). The PRM expresses the correct longstanding policy, indicating that both inpatient and outpatient training costs are allowable for pass-through payment. We are correcting the regulations at § 413.85(c)(2) and § 413.85(d)(1)(i)(C) to indicate that "approved educational activities" are those that "Enhance the quality of health care at the provider." However, costs of training activities occurring in areas of the hospital other than the IPPS or OPPS areas or in nonprovider settings continue to not be allowed for pass-through payment.

I. Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs (§ 412.113)

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 Pub. L. 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) 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 nor hospitals that have reclassified from urban to rural under the regulations at § 412.103 and neither CAHs nor hospitals located in Lugar counties are eligible to receive pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists. However, because the statute, as revised by section 608 of Public Law 100–485, allows 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 believe our regulations should likewise permit urban hospitals that have been reclassified as rural under section 1886(d)(8)(E) of the Act to qualify for these payments. Therefore, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24010), we proposed 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 also are 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 did not propose 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, in the proposed rule, we stated that we do not believe it would be consistent with the statute and our regulations to permit these facilities to also be paid on a reasonable cost basis for anesthesia services and related care furnished by qualified nonphysician anesthetists.

Comment: Several commenters supported CMS' proposal to provide for reasonable cost-based payment for anesthesia services and related care furnished by qualified nonphysician anesthetists in rural hospitals and CAHs that have reclassified under § 412.103. One commenter stated there are three facilities in its State that would now qualify for CRNA reasonable cost-based payments and that the State hospital association had been working with CMS and Congress for several years to address this issue. One commenter stated that the role of CRNAs in small rural CAHs includes, in addition to administering and maintaining anesthesia, airway management, IV starts, and other triage, trauma, and emergency services. The commenter stated that, at its facility, CRNAs take call 24 hours a day, 7 days a week and their clinical skills help to provide constant emergency and obstetric services. Another commenter in a large State noted that the proposed policy would increase access to essential anesthesia services in rural areas of the State, allowing CAHs and rural hospitals to provide continuous surgical and maternity coverage. One commenter stated the proposed policy would allow three CAHs in its State, which previously received CRNA reasonable cost-based payments and were excluded from such payment in 2005, to once again be paid based on reasonable cost for anesthesia services and related care furnished by qualified nonphysician anesthetists.

Response: We appreciate the commenters' support of CMS' proposed policy to provide rural hospitals and CAHs that have reclassified under § 412.103 with reasonable cost-based payments for anesthesia services and related care furnished by qualified nonphysician anesthetists.

Comment: Although commenters supported the proposed policy regarding payment for services provided by qualified nonphysician anesthetists, the majority of commenters disagreed with CMS' statement in the proposed rule that it was not proposing to change its policy to provide for reasonable cost-based payment for services furnished by qualified nonphysician anesthetists in facilities located in Lugar counties (75 FR 24011). Several commenters stated that, in the proposed rule, CMS proposed to revise the regulations, which limited reimbursement for CRNA services provided in CAHs to the Medicare Resource-Based Relative Value Scale, to allow for cost-based reimbursement for these services. The commenters stated that while the proposed rule would allow for reimbursement for CRNA services based on cost, the proposal does not include CAHs located in Lugar counties; instead, these facilities would continue to be reimbursed using the Medicare Physician Fee Schedule. The commenters stated that this policy approach is inappropriate. Commenters stated that they believed there may be some confusion that CAHs located in Lugar counties receive a financial advantage. These commenters stated that CAHs located in Lugar counties do not receive any benefit from being located in such counties because CAHs are reimbursed based on cost and not based on Medicare DRG payments. Commenters stated that CAHs located in Lugar counties are faced with "double jeopardy" because these CAHs do not receive the higher DRG payments that IPPS hospitals receive as a result of being located in a Lugar county, nor do they receive CRNA reasonable cost-based payments. Commenters stated that very few CAHs are located in Lugar counties and therefore a change in CMS' policy to enable these CAHs to receive CRNA reasonable cost-based payments would have a very small financial impact on the Medicare program. Another commenter stated that in its State, there are at least 13 CAHs that would be negatively affected by the proposed provision.

Commenters referenced the FY 2006 IPPS final rule (70 FR 47469), where CMS stated the Lugar provision does not apply in determining CAH status because the Lugar provision applies for

purposes of payment under the IPPS and CAHs are not subject to the IPPS. The commenters stated that as a result of the policy published in the FY 2006 IPPS final rule, CAHs located in Lugar counties have not sought to reclassify as rural for purposes of CAH designation. Many commenters stated that it is inappropriate for CMS to state that Lugar designation does not apply to CAHs in one context, for determining CAH eligibility, but does apply for the purpose of determining whether a CAH will receive CRNA reasonable cost-based payments. One commenter requested that if CMS does not change its policy with respect to CAHs located in Lugar counties and CRNA reasonable cost-based payment that "* * * the broad powers conferred upon the Secretary by Congress be used to resolve such conflict and correct this issue for CAHs located in Lugar counties." One commenter stated that, in 2005–2006, CMS issued provisions allowing facilities already certified as CAHs, which were classified as urban, an opportunity to reclassify as rural based on either the CAH's ability to comply with either the Federal or State definition of rural. The commenter referenced language included in an April 25, 2005 memorandum which referred to a proposal discussed in the FY 2006 IPPS proposed rule, in which CMS proposed to clarify that CAHs that were located in a county that, in FY 2004, was not part of a Lugar county, but as of FY 2005 were included in such a county as a result of the labor market area definitions announced by OMB on June 6, 2003, had through September 30, 2006, to reclassify as rural under § 412.103 of the regulations. The commenter stated that the two CAHs in its State located in Lugar counties were reclassified as rural prior to October 2006, and these facilities were able to maintain their CAH status. The commenter stated that "Excluding CAHs located in Lugar counties, because of lack of clarity with [the] definition and fear [that] Lugar county reimbursement is an advantage for CRNAs, is not accurate." One commenter stated that CMS' proposal not to permit CAHs located in Lugar counties to receive CRNA reasonable cost-based payments is not supported by section 1886(d)(8)(B) of the Act. The commenter stated that the only basis for excluding rural CAHs such as its facility, is that CMS believes that section 1886(d)(8)(B) of the Act converts these CAHs into urban facilities if they are located in Lugar counties. The commenter quoted the statutory language at section 1886(d)(8)(B) of the Act: "For purposes of this section, the Secretary shall treat a *hospital* located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area * * *" (emphasis added by commenter). The commenter further referred to section 1861(e) of the Act, which states the "* * * term 'hospital' does not include, unless the context otherwise requires, a critical access hospital (as defined in section 1861(mm)(1))." The commenter stated that because section 1886(d)(8)(B) of the Act describes the geographic classification for subsection 1886(d) hospitals, which CAHs are not, "it is clear that the 'context does not require' incorporating CAHs into the definition of hospital for such purposes." Therefore, the commenter believes section 1886(d)(8)(B) of the Act, does not change CAHs located in Lugar counties into urban facilities. The commenter stated that because CAHs in Lugar counties do not lose their rural status, they must remain eligible for CRNA reasonable cost-based payments despite being located in a Lugar county. The commenter stated that its facility did not apply for reclassification under § 412.103 when it applied for CAH designation, which supports the claim that its facility (a CAH located in a Lugar county) is a rural facility.

Response: We thank the commenters for their comments. In response to the commenters who stated that CMS proposed to revise a longstanding regulation that limited Medicare reimbursement for CRNA services provided in CAHs to the Medicare Resource-Based Relative Value Scale amounts in lieu of cost, we note that CAHs located in a rural area as defined at section 1886(d)(2)(D) of the Act were eligible to receive CRNA reasonable cost-based payments prior to this final rule. In response to the commenter who referred to a provision included in the FY 2006 IPPS proposed rule, where CMS proposed to clarify that CAHs located in Lugar counties as a result of the labor market areas definitions announced by OMB on June 6, 2003, could reclassify as rural through September 30, 2006, we note that, in the FY 2006 IPPS final rule, we adopted a policy that, for purposes of CAH participation, a CAH located in a Lugar county is considered to be located in a rural area. In response to the commenters who disagreed with our proposal not to extend reasonable cost-based payments for nonphysician anesthesia services to facilities located in Lugar counties, we continue to believe, consistent with the plain language of the applicable statutory provisions, that it is appropriate to exclude hospitals and CAHs located in Lugar counties from reasonable cost-based payment for anesthesia services and related care furnished by qualified nonphysician anesthetists. Section 608 of the Family Support Act of 1988 (Pub. L. 100–485) amended section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) to state: "* * * the amendments made by this section shall not apply during 1989, 1990, and 1991 to a hospital located in a rural area (*as defined for purposes of section 1886(d) of the Social Security Act*) * * *" (emphasis added). Section 1886(d) of the Act includes both sections 1886(d)(8)(B), the Lugar provision, and section 1886(d)(8)(E), the reclassification provision. Section 1886(d)(8)(B) of the Act treats facilities located in Lugar counties as urban facilities and section 1886(d)(8)(E), treats urban facilities that have reclassified under that section as rural facilities. Therefore, "as defined for purposes of section 1886(d) of the Social Security Act" clearly indicates that Lugar facilities are urban for purposes of receiving CRNA reasonable cost-based payment and those facilities that have reclassified under section 1886(d)(8)(E) of the Act are rural for purposes of receiving CRNA reasonable cost-based payments.

In response to commenters who stated CMS' position that facilities located in Lugar counties can be granted CAH status but these same facilities are not eligible to receive CRNA reasonable cost-based payments is inconsistent, CAH status and CRNA reasonable cost-based payments are determined through the application of two separate and distinct provisions under the Act. Section 1820(c)(2)(B)(i) of the Act permits a facility to qualify for designation as a CAH only if it is located "in a rural area (as defined in section 1886(d)(2)(D)) or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E). * * *" Because section 1820(c)(2)(B)(i) of the Act does not include any reference to the Lugar provision (section 1886(d)(8)(B) of the Act), we do not believe that the statute requires CMS to treat a facility as being in an urban area for purposes of CAH participation if it is in a Lugar county. That is, the specific omission of section 1886(d)(8)(B) from section 1820(c)(2)(B)(i) of the Act indicates that being located in a Lugar county may be considered irrelevant for purposes of CAH designation. Consistent with this reading of section 1820(c)(2)(B)(i) of the Act, in the FY 2006 IPPS final rule, we amended the CAH regulations at

§ 485.610(b)(1)(i) to remove all references to a facility being recognized as urban under the regulations implementing the Lugar provision. The effect of this change was that facilities in Lugar counties are now considered to be located in rural areas for purposes of CAH participation. In the FY 2006 IPPS final rule, we emphasized that this change was "effective only for purposes of CAH participation and will not otherwise affect the status of hospitals or CAHs in Lugar counties (70 FR 47469).

In contrast, in order to qualify for reasonable cost-based payments for CRNA services, a facility must be rural "as defined for purposes of section 1886(d) of the Social Security Act," which we believe includes all of the designations at section 1886(d) of the Act, including sections 1886(d)(8)(B) and 1886(d)(8)(E). Because section 608 of the Family Support Act of 1988 refers to all of section 1886(d) of the Act, we interpret this to encompass all of the area designations included in section 1886(d) of the Act, including section 1886(d)(8)(B). That is, because section 608 of the Family Support Act referenced section 1886(d) of the Act and not just section 1886(d)(2)(D), we continue to believe it is appropriate to preclude CRNA reasonable cost-based payments to those hospitals and CAHs located in Lugar counties. In addition, we believe that if we recognize as rural the urban-to-rural hospitals that have reclassified under section 1886(d)(8)(E) of the Act, we should also recognize as urban the Lugar hospitals that are redesignated pursuant to section 1886(d)(8)(B) of the Act. Both of these provisions are incorporated within subsection (d), and we believe it is most internally consistent to recognize both reclassifications, rather than recognizing one type of reclassification without recognizing the other. Finally, we note that hospitals and CAHs located in Lugar counties could apply to reclassify under § 412.103 of the regulations and thus become eligible to receive reasonable cost-based payments for anesthesia services and related care furnished by qualified nonphysician anesthetists.

Comment: One commenter opposed CMS' proposal to reimburse facilities that have reclassified under § 412.103 at 100 percent of reasonable cost for anesthesia and related services provided by qualified nonphysician anesthetists. The commenter stated that, starting in 2002, when the regulations were revised to increase the cap on surgical procedures from 500 to 800 to qualify for CRNA reasonable cost-based payments, the commenter requested that CMS review the law and its regulations to determine whether the regulations could be revised to include anesthesiologists in the same reasonable cost-based payments that other anesthesia providers receive. The commenter stated that not providing equitable payment to anesthesiologists who work in rural settings prohibits patients from receiving high-level anesthesia services, which CRNAs lack the training or licensure to provide. The commenter stated CMS' current regulations regarding reasonable cost-based payment for anesthesia services discourages rural hospitals from employing or contracting with anesthesiologists. The commenter stated that, due to the lack of anesthesiologists in rural hospitals, these hospitals are forced to transfer medically complex patients to large urban hospitals, which results in greater risk and inconvenience to the patient. The commenter urged CMS not to finalize its proposal until all anesthesia providers are eligible to be paid based on reasonable cost. The commenter stated that not finalizing CMS' proposal is reasonable due to the uncertainty of how many facilities would be affected by the proposed change. The commenter urged CMS to extend reasonable cost-based payments to services provided by anesthesiologists in rural hospitals and CAHs, and if such a change cannot be made through regulations and CMS makes this determination publicly, that CMS recommend to Congress that the statute be amended to provide for reasonable cost-based payments for anesthesiologist services provided by anesthesiologists in rural hospitals and CAHs. The commenter requested if CMS cannot establish the current number of facilities that would be eligible for reasonable cost-based payments, prior to making any change which would expand the number of facilities that could be eligible for reasonable cost-based payments, CMS should provide a list of hospitals or CAHs that would have been eligible to receive reasonable cost-based payments in previous years.

Response: Reasonable cost-based payment for anesthesia services and related care does not apply to physician anesthesiologists under section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) and prior applicable legislation. Physician anesthesiologists receive payment under the Medicare Physician Fee Schedule. Therefore, under current law, CMS does not have the authority to extend reasonable cost-based payment to rural hospitals and CAHs for anesthesia services and related care furnished by physician anesthesiologists. We appreciate the commenter's concern that access to high-level anesthesia services may not be adequate in rural areas because there may be a limited number of physician anesthesiologists practicing in these areas. However, we believe that not finalizing our proposal to extend reasonable cost-based payments for services furnished by qualified nonphysician anesthetists in rural hospitals and CAHs that reclassified under § 412.103 would run counter to this very concern, that access to anesthesia services is limited in rural areas. That is, not extending reasonable cost-based payment for anesthesia services and related care furnished by qualified nonphysician anesthetists to rural hospitals and CAHs that reclassify under § 412.103 would, in fact, further limit access to anesthesia services.

Comment: One commenter requested that the effective date of the proposed policy on payment for anesthesia services and related care for qualified nonphysician services be changed from cost reporting periods beginning on or after October 1, 2010 to calendar years beginning on or after January 1, 2011 because the CRNA reasonable cost-based payment elections are made on a calendar year basis rather than a cost reporting year basis. Another commenter stated CMS should not force rural hospitals and CAHs affected by this proposed provision to engage in appeals of this issue due to CMS' unwillingness to revise the regulations as a result of the statute as revised by the Family Support Act of 1988. The commenter stated court cases such as *Bayside Community Hospital* v. *Sebelius* have considered this issue and have maintained "It is true that the physical location of the hospital does not change; however, Congress has directed that a hospital qualifying under 1886(d)(8)(E) be treated as if it were in a rural location. The purpose of this is to overcome the actual physical location and cause a hospital to qualify as rural. Thus, the deeming provision does impact the definition of rural at section 1886(d). A regulation does not override a clearly stated statute." The commenter stated that, to prevent litigation for all parties involved, it would be efficient if CMS modified the proposed provision as a clarification effective as of 1988 and direct that for all cost reports that have an appropriate pending appeal, all open cost reports, and all cost reports that are within three years of settlement, CAHs and hospitals that have reclassified under section 1886(d)(8)(E) of the Act are eligible to be paid on a reasonable cost basis for anesthesia services and

related care furnished by qualified nonphysician anesthetists.

Response: The provisions published in the IPPS final rule for each respective year are generally effective October 1 of that respective year. Therefore, we proposed that this provision be effective for cost reporting periods beginning on or after October 1, 2010. Although the commenter requested that the proposal be amended to state that it would be effective for calendar years beginning on or after January 1, 2011, we do not believe this change is necessary because if the provision is effective for cost reporting periods beginning on or after October 1, 2010, it will also be in effect for the calendar year beginning January 1, 2011.

In response to the commenter who requested that the proposed provision be applied retroactively to the effective date of the Family Support Act of 1988, section 1871(e)(1)(A) of the Act generally prohibits the Secretary from making retroactive substantive changes in policy unless retroactive application of the change is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest. We do not believe this provision meets such a threshold.

Comment: Several commenters addressed issues regarding reasonable cost-based payment for on-call services provided by CRNAs as well as stand-by costs. In general, commenters requested that reasonable cost-based payments include on-call CRNA costs as allowable costs. One commenter requested that CMS consider amending the regulations to provide for an exception to the requirement that a hospital or CAH must have employed or contracted with a qualified nonphysician anesthetist as of January 1, 1988, as one of the requirements to be eligible for reasonable cost-based payments.

Response: We consider these comments to be outside of the scope of the proposed rule and, therefore, are not responding to them in this final rule.

Comment: One commenter requested that CMS change the CoPs to remove the requirement for physician supervision in CAHs.

Response: We consider this comment to be outside of the scope of the proposed rule. Therefore we are not responding to the comment in this final rule.

After consideration of the public comments that we received, we are adopting, as final without modification, our proposal 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.

J. Additional Payments for Qualifying Hospitals With Lowest Per Enrollee Medicare Spending

1. Background

Section 1109 of Public Law 111–152 provides for additional payments for FY 2011 and 2012 for "qualifying hospitals." Section 1109(d) defines a "qualifying hospital" as a "subsection (d) hospital * * * that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B * * * per enrollee within the lowest quartile of such counties in the United States." Therefore, a "qualifying hospital" is one that meets the following conditions: (1) A "subsection (d) hospital" as defined in section 1886(d)(1)(B) of the Act; and (2) located in a county that ranks within the lowest quartile of counties based upon its spending for benefits under Medicare Part A and Part B per enrollee adjusted for age, sex, and race. Section 1109(b) of Public Law 111–152 makes available $400 million to qualifying hospitals for FY 2011 and FY 2012. Section 1109(c) of Public Law 111–152 requires the $400 million to be divided among each qualifying hospital in proportion to the ratio of the individual qualifying hospital's FY 2009 IPPS operating hospital payments to the sum of total FY 2009 IPPS operating hospital payments made to all qualifying hospitals.

2. Eligible Counties

Section 1109 of Public Law 111–152 provides $400 million for FYs 2011 and 2012 for supplemental payments to qualifying hospitals located in counties that rank within the lowest quartile of counties in the United States for spending for benefits under Medicare Part A and Part B. The provision requires that the Medicare Part A and Part B county-level spending per enrollee be adjusted by age, sex and race. In the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30926 through 30960), we proposed our methodology for determining the bottom quartile of counties with the lowest Medicare Part A and Part B spending adjusted by age, sex, and race and invited public comment on the methodology we proposed to use to adjust for age, sex, and race described below. We further proposed that we would determine this bottom quartile of counties one time in this FY 2011 IPPS/LTCH PPS final rule for the purpose of disbursing the $400 million as required by section 1109 of Public Law 111–152.

We developed an adjustment model by age, sex, and race, as required under the provision. We then applied this adjustment to the county Medicare Part A and Part B spending data to account for the demographics of the Medicare beneficiaries in those counties. After those adjustments are applied, we determined the Medicare Part A and Part B spending by county per enrollee. Our proposed methodology to determine the Medicare Part A and Part B spending per enrollee by county adjusted for age, sex, and race is similar to how we calculate risk adjustment models for Medicare Advantage (MA) ratesetting. Risk adjustment for MA ratesetting is discussed in the annual announcement of calendar year MA capitation rates and MA and Part D payment policies. For more information on the methodology for risk adjustment used for MA ratesetting, we refer readers to the CMS Web site where we announce MA rates through our 45-day notice (*http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf*).

a. Development of Risk Adjustment Model

As required by section 1109(d) of Public Law 111–152, we proposed a risk adjustment model that accounts for differentials in Medicare spending by age, sex, and race. Consistent with how we develop our risk adjustment models for MA ratesetting as described above, we developed a prospective risk adjustment model using 2006 data for beneficiary characteristics and 2007 data for Part A and Part B spending. However, unlike the risk adjustment model used for MA which includes diseases and demographic factors, the only independent variables or prospective factors in the model for payments under section 1109 of Public Law 111–152 are age, sex and race, as required by the provision. The dependent variable was annualized Medicare Part A and B spending at the beneficiary level for 2007 as it is the most recent and complete data available. The categorization of age, sex, and race variables are described below.

The age, sex, race (ASR) model(s) was estimated using 5-percent of the Standard Analytic Denominator File, a standard 5-percent sample from the 2007 Denominator File which is also used to estimate CMS risk adjustment

models for payment to MA organizations. We chose to use the 5-percent Standard Analytic Denominator File from 2007 in order to optimize the amount of time after the timely claim submission deadlines and the latest available data; in other words, because it is the most complete data currently available. This file has the demographic and enrollment characteristics of all Medicare beneficiaries. The Denominator File is an abbreviated file of the Enrollment Data Base (EDB). The Denominator File contains data on all Medicare beneficiaries enrolled and/or entitled to be enrolled in Medicare in a given year while the EDB is the source of enrollment and entitlement information for all people who are or were ever entitled to Medicare. The model was estimated using all beneficiaries residing in the community and long-term care institutions. The sample had 1,603,998 beneficiaries.

The Denominator File contains a sex variable where the beneficiaries can identify themselves as male or female. The file also contains an age variable which is defined as the beneficiary's age at the end of the prior year. Beneficiaries with an age greater than 98 are coded as age 98. The race demographic variable in the Denominator File is populated by data from the Social Security Administration (SSA). The SSA's data for this race demographic variable are collected on Form SS–5. Prior to 1980, Form SS–5 included three categories for race: White, Black or Other. Since that time, Form SS–5 instructed a beneficiary to voluntarily select one of the following five categories: (1) Asian, Asian-American or Pacific Islander; (2) Hispanic; (3) Black (Not Hispanic); (4) North American Indian or Alaskan Native; and (5) White (Not Hispanic). Form SS–5 is completed when an individual does the following: (1) Applies for a Social Security number; (2) requests a replacement of the Social Security card; or (3) requests changes to personal information on their record such as a name change. (We refer readers to the SSA Web site for instructions at: *http://ssa.gov/online/ss-5.pdf*). Each January, CMS obtains data from SSA to update the EDB for beneficiaries who were added during the previous calendar year as well as all living beneficiaries whose race is identified as "Other" or "Unknown."

Discussed in the context of the ESRD payment system in the ESRD proposed rule on September 29, 2009 (74 FR 49962), we noted concerns with using the EDB as a data source due to missing data, and that racial and ethnic categories are not well defined. However, we believe that the current EDB, particularly with respect to the more recent and ongoing updates we perform, remains a useful source of race and ethnicity data on 46 million Medicare beneficiaries. Additionally, because this is our only currently available data source on the racial and ethnic demographics of Medicare beneficiaries, we proposed to the use the EDB as our data source for beneficiary race so that we can fulfill the requirements of section 1109(d) of Public Law 111–152 to adjust county Medicare Part A and Part B spending by race.

We used the MedPAR claims file as the source to determine Medicare inpatient spending. We used the National Claims History File to determine spending on DMEPOS and supplies. The other spending under Medicare Part A and Part B was determined using the Standard Analytic File. The Standard Analytic File and MedPAR claims file are subsets of the National Claims History File. These data files are also used in the MA ratesetting process and are our data source for Medicare spending stored at the beneficiary level.

In order to determine annual spending (the dependent variable in the risk adjustment model), we annualized the Medicare Part A and Part B spending for beneficiaries with less than a full year of eligibility, and these amounts were weighted in the analysis by the fraction of the year they were in the data.

We used a linear regression model to determine the demographic adjustments. This is consistent with how we model our risk adjustment for the MA rates. The linear regression used 24 age-sex regression categories, 12 age categories each for males and females. The age categories are as follows; 0–34, 35–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, 85–89, and 90+. The age-sex coefficients displayed in the table below reflect the difference in Medicare Part A and Part B spending per enrollee in those age-sex categories relative to national average Part A and Part B spending based on our linear regression model.

In addition, we used the same linear regression model to determine how to adjust Medicare Part A and Part B spending for race. In addition to the age-sex regression categories described above, we included variables to adjust for race. We considered two methods to adjust for race in county spending because of the way that Form SS–5 collects race information, which is then reported in the same format in the EDB. As discussed earlier, the EDB currently categorizes race by the following five categories, as reported by the Medicare beneficiary: (1) Asian, Asian-American or Pacific Islander; (2) Hispanic; (3) Black (Not Hispanic); (4) North American Indian or Alaskan Native; and (5) White (Not Hispanic). One method categorized race by White, Black, Hispanic, and Other (WBHO). The "Other" category includes Asian/Pacific Islander, American Indian/Alaska Native, and all others. The second method categorized race by White, Black, and Other (WBO), where beneficiaries who identified themselves as Hispanic were categorized as Other. The race/ethnicity categories are mutually exclusive; if a beneficiary identified themselves as Hispanic he or she was not further classified as another category, such as White or Black. In our regression modeling, we used the largest group, White, as the reference group; the coefficients on the difference in spending by race, displayed in the table below, are additive to the reference group. In other words, the coefficients for each race category represent the difference in predicted Medicare Part A and Part B spending relative to our reference group. Where the coefficients are positive, this implies that the predicted spending for that category is higher than that of the reference group. Conversely, where the coefficients are negative, this implies that the predicted spending for that category is lower than that of the reference group.

Below are two tables representing the coefficients used to adjust Medicare Part A and Part B spending by county. The first table shows the coefficients for each age and sex category. The second table shows the coefficients for race. These national coefficients are applied to each counties' relative demographic for age, sex and race, so that each county has a risk score by age, sex and race.

Sex	Age Categories (in years)											
	0-34	35-44	45-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	Greater than 95
Female	0.67896	0.80089	0.96917	1.09810	1.18855	0.67358	0.83818	1.01599	1.189727	1.364575	1.475495	1.366515
Male	0.52664	0.70067	0.82262	0.93750	1.03792	0.71932	0.90896	1.11809	1.32812	1.50008	1.68184	1.77046

Race	Coefficient
White	Baseline
Black	0.17667
Hispanic	0.229
Other	-0.110

We proposed to adjust for race using the WBHO method where we separately account for cost differences associated with Hispanic beneficiaries. The Office of Management and Budget (OMB) has promulgated standards for the classification of federal data on race and ethnicity. Under OMB's classification standards, the category of Hispanic is treated as an ethnic category as opposed to a race category. The current OMB Standards of 1997 require collection of specific demographic data using a total of five race categories, plus other (62 FR 58782 through 58790). The five race categories are—(1) American Indian or Alaska Native; (2) Asian; (3) Black or African American; (4) Native Hawaiian or Other Pacific Islander; and (5) White. In addition, OMB specified two separate ethnic categories—Hispanic or Latino, and not Hispanic or Latino. However, as explained above, Hispanic or Latino ethnicity is treated as a race category by EDB, and beneficiaries can self-identify as Hispanic among mutually exclusive racial categories. Despite the inconsistency in reporting by the OMB and the EDB, we proposed to treat the category of Hispanic as a separate category for purposes of the race adjustment required by section 1109 of Public Law 111–152. We found that the coefficient for the Hispanic category was statistically significant, suggesting that Medicare Part A and Part B spending associated with this category of beneficiaries is different from the spending for our reference group and that it should be a separate coefficient to adjust county spending. In addition, the EDB treats Hispanic as a separate racial classification, consistent with our WBHO method. Therefore, we believe that our proposal appropriately interpreted the required race adjustment. In the supplemental proposed rule, we proposed to adjust for race using the WBHO method.

For purposes of the supplemental proposed rule, we also adjusted county spending using the WBO methodology to compare the two approaches. We found minimal difference in the county rankings under the two methodologies. We found that some counties would qualify as an eligible county only under the WBO methodology, and others would no longer qualify as an eligible county using this alternative. The decision to use the WBHO methodology affects whether nine subsection (d) hospitals, located in five counties, would be eligible to receive a payment under section 1109 of Public Law 111–152. In Table 3 of the supplemental proposed rule (75 FR 30949 through 30958), we published the differences in counties, eligible hospitals, and payments by State under the two methodologies. This was the first time we had developed an adjustment for Medicare spending based on race, and we welcomed public comment on our proposal to use the WBHO methodology to adjust for race as required by section 1109 of Public Law 111–152. We also welcomed public comment on the WBO methodology to adjust for race though we noted that we were not proposing this methodology at this time.

b. Calculation of County Level Part A and Part B Spending

In order to rank counties by Medicare Part A and B spending, we first calculated Medicare Part A and Part B county level spending for each county in the 50 States and the District of Columbia using a similar methodology used to establish county level fee-for-service rates for MA payments. Using a 5-year average of each county's actual spending (from 2002 to 2006), our actuaries calculated an average geographic adjuster (AGA), which reflects the county's expenditure relative to the national expenditure. We believe a 5-year average is appropriate, as it accounts for fluctuations in year-to-year expenditures, which could distort the counties' historic level of spending and is consistent with how MA rates are calculated. The AGA was then applied to the 2009 United States Per Capita Cost (USPCC) estimate, which is the national average cost per Medicare beneficiary, to determine 2009 Medicare Part A and Part B spending for each county. We welcomed public comment on this methodology to calculate county-level Medicare Part A and Part B spending.

3. Application of the Age/Sex/Race Adjustment to Part A and Part B County Spending

To estimate the county level risk scores for 2009, beneficiary enrollment information was first extracted from the EDB. We chose to calculate Medicare Part A and Part B county spending for 2009 to be consistent with how we are required to determine qualifying hospitals' payment amounts, under section 1109(c) of Public Law 111–152. That is, section 1109(c) of Public Law 111–152 requires that qualifying hospitals located in the bottom quartile

of counties with the lowest Medicare Part A and Part B spending per enrollee will receive a portion of the allotted $400 million based on their FY 2009 operating payments. Therefore, we proposed to calculate Medicare Part A and Part B county spending for 2009 as well. We only included beneficiaries enrolled in Medicare Part A and/or Part B, consistent with the language of section 1109(d) of Public Law 111–152, which refers to spending under Medicare Part A and Part B. Based on these criteria, there were 30,666,295 beneficiaries included in the adjustment process. To determine the age, sex and race makeup of the Part A and/or Part B beneficiaries for each county, we used the EDB to identify date of birth, sex, race, and State/county of residence to create a person-level file with the data needed to run the ASR model.

A county-level average risk score was developed for each county in the United States by applying the ASR model to each individual in the county enrolled in Medicare Part A and/or Part B, summing the resulting risk scores and dividing by the number of beneficiaries by county enrolled in Medicare Part A and/or Part B. The county-level Medicare Part A and/or Part B spending was adjusted by dividing the county-level Medicare Part A and/or Part B spending by the county-level average risk score. The resulting spending distribution was then sorted lowest to highest dollars; the 786 counties in the lowest quartile of spending (that is, lowest adjusted spending per enrollee) were determined to be eligible counties under section 1109 of Public Law 111–152.

We invited comment on our methodology for determining the age, sex, race adjustments for determining adjusted Medicare Part A and B spending by county for the purpose of determining eligible counties under section 1109 of Public Law 111–152.

Comment: Some commenters supported the proposed methodology for determining the eligible counties, calculating the county rates, identifying the qualifying hospitals and allocating the allotted payments.

Response: We appreciate the comments in support of our methodology. We are finalizing our proposed methodology, with a few adjustments in response to specific comments discussed below, in this final rule.

Comment: Some commenters expressed disappointment that CMS did not provide data to determine which hospitals qualify for payments, including those used for the risk-adjustment model, calculation of the county-level spending and application of the risk-adjustments to the Part A and Part B spending. Commenters requested that CMS publish the data used to calculate the ASR model, the county spending, and the FY 2009 IPPS operating payments for the qualifying hospitals.

Response: As the commenters noted, several data sources were used to calculate our age-sex-race adjustments, the county-level Medicare Part A and Part B spending per enrollee, and our qualifying providers' payment weighting factors. As discussed above, our data source to calculate the ASR model was the 2007 Standard Analytic File, which is a 5-percent sample of the Denominator File. In addition, to calculate spending for the ASR model, we used the MedPAR claims file to calculate inpatient spending, the National Claims History File to calculate DMEPOS and supplies spending, and the Standard Analytic File to calculate other Medicare Part A and Part B spending from 2007. The Standard Analytic File is available for purchase from CMS (as discussed in section IV.J.6. of this preamble). Additional information on this file can be found on the CMS Web site at: *http://www.cms.gov/LimitedDataSets/12_StandardAnalyticalFiles.asp.*

As described above, to calculate the 2009 unadjusted county spending, we used a 5-year average (from 2002 to 2006) of each county's Medicare Part A and Part B spending to calculate an AGA for each county and applied that to the 2009 USPCC. We calculated the county age-sex-race risk scores based on county demographics from the EDB from 2009 and applied the county age-sex-race risk score to the unadjusted county spending to determine the Medicare Part A and Part B spending adjusted for age, sex and race. We divided this adjusted county-level spending by the number of Medicare Part A and Part B beneficiaries from 2009 in each county.

Soon after the publication of the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we published the proposed unadjusted county rates, the age-sex-race adjustments applied to the county rates, and the county rates adjusted for age-sex-race for the eligible counties on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/IPPS2010/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1235590&intNumPerPage=10.*

We are publishing the final unadjusted county rates, the age-sex-race adjustments applied to the county rates, and the county rates adjusted for age-sex-race for the eligible counties that are included in this final rule on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/IPPS2011/list.asp#TopOfPage.*

To calculate the final payment weighting factors for the qualifying hospitals, we used the actual payments reported on the March 2010 update of the FY 2009 MedPAR file, which, as discussed in section IV.J.6. of this preamble, the public can purchase. As required by the statute, a hospital receives the proportion of the $400 million based on its FY 2009 IPPS operating payments made under section 1886(d) of the Act relative to the FY 2009 IPPS operating payments made to all the qualifying hospitals under section 1886(d) of the Act. We defined IPPS operating payments to include DRG and wage-adjusted payments made under the IPPS standardized amount with add-on payments for operating DSH, operating IME, operating outliers and new technology. We excluded capital PPS payments. As we proposed, we also included IME MA payments made to IPPS hospitals because these payments are made under section 1886(d) of the Act. We only included section 1886(d) IPPS operating payments for cases that occurred in IPPS acute care units of the qualifying hospitals.

Comment: Some commenters opposed the proposed methodology to calculate the Medicare Part A and Part B county spending per enrollee adjusted for age, sex and race. Commenters believed that the methodology should include adjustments for poor health status, incidence of chronic disease or other factors that drive utilization and health care spending.

Response: Section 1109(d) of the Public Law 111–152 specified that we are to calculate Medicare Part A and Part B spending per enrollee adjusted for age, sex and race by county. This specific statutory language did not provide us with any flexibility to include, as part of our adjustment, other factors that may influence Medicare spending. Therefore, we are finalizing our proposed model, which only adjusts Medicare Part A and Part B spending per enrollee at the county level for age, sex and race, as specified by the statute.

Comment: Some commenters requested that CMS use a 3 year's worth of spending data to calculate the AGA instead of our proposal to include 5 years' worth of Medicare spending data to reflect fluctuations in year-to-year spending. Some commenters also requested that CMS use the most recent

spending data through 2008 to calculate the AGA.

Response: In the supplemental proposed rule (75 FR 30928), we discussed our rationale for using a 5-year average of each county's actual spending from 2002 to 2006 to calculate the average geographic adjuster, which reflects a county's expenditure relative to the national expenditure. We believe that a 5-year average accounts for fluctuations in year-to-year spending that could distort counties' level of spending. As explained in the supplemental proposed rule, in order to calculate county spending adjusted for age, sex and race, we followed a methodology similar to the development of the MA fee-for-service (FFS) rates under section 1853(c)(1)(D) of the Act. MA FFS ratesetting uses 5 years' worth of Medicare spending data to calculate the fee-for-service county spending rates. Due to fluctuations in county spending that occur, particularly in counties with few Medicare beneficiaries, our actuaries used 5 years' worth of county-level fee-for-service Medicare spending data to minimize variability for purposes of MA FFS ratesetting. We chose to apply a methodology consistent with MA FFS ratesetting because of our experience under MAFFS ratesetting in calculating Medicare Part A and Part B spending per enrollee at the county level and our experience under MA FFS ratesetting in adjusting for factors that can influence spending such as age and gender. We believe that, subject to the specific requirements of section 1109 of Public Law 111–152, we should use the same methodology that we use to develop the fee-for-service rates under section 1853(c)(1)(D) of the Act in MA ratesetting.

In response to the commenters' suggestions that we use data through 2008, we are not adopting these suggestions. Instead, we are using 2002 to 2006 data to calculate the AGA to be consistent with how 2009 MA FFS rates were calculated for the reasons explained above. We note that the average geographic adjuster using 2002 to 2006 data is then applied to 2009 USPCC to calculate the 2009 spending rates, where the USPCC includes more recent spending data.

After consideration of the public comments we received, we are finalizing, without change, our proposed methodology to calculate our Medicare Part A and Part B county spending per enrollee, which uses 5 years' worth of Medicare spending data from 2002 to 2006 to calculate the AGA and adjusts for age, sex, and race.

4. Qualifying Hospitals and Annual Payment Amounts

We have developed a methodology to identify the qualifying hospitals located in our list of eligible counties. Consistent with section 1109(d) of Public Law 111–152, a qualifying hospital is a "subsection (d) hospital" (as defined for purposes of section 1886(d) of the Act) that is "located in" an eligible county (as identified using the methodology we proposed and discuss in section IV.J.2. of this preamble). A subsection (d) hospital is defined in section 1886(d)(1)(B) of the Act, in part, as a "hospital located in one of the 50 States or the District of Columbia". The term "subsection (d) hospital" does not include hospitals located in the territories or hospitals located in Puerto Rico. Section 1886(d)(9)(A) of the Act separately defines a "subsection (d) Puerto Rico hospital" as a hospital that is located in Puerto Rico and that "would be a subsection (d) hospital * * * if it were located in one of the 50 States." Therefore, Puerto Rico hospitals are not eligible for these additional payments. Indian Health Services hospitals enrolled as Medicare providers meet the definition of a subsection (d) hospital and can qualify to receive this payment if they are located in an eligible county. In addition, hospitals that are MDHs and SCHs, although they can be paid under a hospital-specific rate instead of under the Federal standardized amount under the IPPS, are "subsection (d)" hospitals. The statutory definition of a "subsection (d)" hospital in section 1886(d)(1)(B) of the Act specifically excludes hospitals and hospital units excluded from the IPPS, such as psychiatric, rehabilitation, long term care, children's, and cancer hospitals. In addition, CAHs are not considered qualifying hospitals because they do not meet the definition of a "subsection (d) hospital" as they are paid under section 1814(l) of the Act. CAHs are not paid under the IPPS. Rather, they are paid under a reasonable cost methodology and, therefore, do not meet the definition of "qualifying hospital" under section 1109(d) of Public Law 111–152.

For the purposes of section 1109 of Public Law 111–152, we proposed to identify "qualifying hospitals" based on their Medicare provider number or CMS certification number (CCN), because one of these numbers is also how hospitals identify themselves when they file their Medicare cost reports. We also proposed that, in order to meet the definition of a "qualifying hospital," the hospital, as identified by the Medicare provider number or CCN, must: (1) Have existed as a subsection (d) hospital as of April 1, 2010; (2) be geographically located in an eligible county; and (3) have received IPPS operating payments (in accordance with section 1886(d)) of the Act) under its Medicare provider number or CNN in FY 2009. We used the Online Survey, Certification and Reporting (OSCAR) database to determine a hospital's county location associated with that Medicare provider number or CCN. County data in OSCAR is supplied by the U.S Postal Service and is crosswalked to the address reported by the provider. Under this proposal, the address listed for a hospital's Medicare provider number must be currently located in a qualifying county in order for a hospital to meet the definition of a "qualifying hospital."

We published a list of the qualifying IPPS hospitals that we identified based on the factors described above in Table 3 of the supplemental proposed rule. We invited comment on our methodology for identifying qualifying hospitals. We also invited comment on whether our list was accurate and whether any providers were missing from this list using the methodology described above.

Comment: Several commenters identified specific providers that were located in an eligible county, but were not included in the listing of qualifying hospitals in Table 3 of the supplemental proposed rule. Commenters stated that Augusta Medical Center (provider number 490018) and Carilion New River Valley (provider number 490042) are located in eligible counties but were not listed in Table 3 as qualifying hospitals. Commenters requested that these providers be included as qualifying hospitals.

Response: We have verified the locations of these providers and have found them to be located in eligible counties. These providers will receive a portion of the $400 million for FY 2011 and FY 2012. We have included these providers in Table 2 of this final rule and have included a payment weighting factor for them.

Comment: Commenters stated that the county locations of certain qualifying hospitals were mislabeled. Specifically, commenters stated that the county locations of Halifax Regional Hospital (provider number 490013), North Hawaii Community Hospital, Cibola General Hospital (provider number 320037) and Acoma Canoncito Laquna PHS hospital (provider number 320070) were mislabeled.

Response: We listed these providers as qualifying hospitals in the proposed rule, but had misidentified their SSA county location. (The SSA county

location is found in the OSCAR database used to identify hospitals located in eligible counties.) We have corrected the SSA county locations of these providers and they remain qualifying hospitals under section 1109 of Public Law 111–152 because their correct SSA county locations are eligible counties.

Comment: Several commenters stated that the names associated with the county codes in supplemental county data posted on the CMS Web site were incorrectly labeled. Specifically, commenters stated that the labels for both SSA county codes 06064 and 06060 were listed as Boulder County, CO. In addition, commenters stated that the labels for both SSA county codes 12020 and 12030 were listed as Honolulu County, HI.

Response: We verified our SSA county code listing. We have determined that SSA county code 06064 is Broomfield County, CO, and SSA county code 06060 is Boulder County, CO. We are finalizing that SSA county code 06064 (Broomfield County CO) is an eligible county, but SSA county code 06060 (Boulder County CO) is not an eligible county. In addition, SSA county code 12020 has been corrected to be the sole county code for Honolulu County, HI, and SSA county code 12030 is corrected to indicate that it refers to Kalawao County, HI. Hawaii County, HI, with an SSA county code of 12030, is an eligible county, as proposed. Kalawao County, HI, with an SSA county code of 12030, is not an eligible county. Correcting the county names associated with these county codes does not impact the list of qualifying hospitals. We have corrected the supplemental county data that is posted on the CMS Web site.

Comment: One commenter stated that CMS had failed to list several Colorado hospitals located in SSA county code 06060, which the commenter believed to be an eligible county, and that these hospitals are qualifying hospitals under section 1109 of Public Law 111–152. In addition, the commenter stated that a hospital located in SSA county code 06500 should be included as a qualifying hospital.

Response: SSA county code 06060 is Boulder County, CO. In Table 2 of the supplemental proposed rule, we inadvertently labeled SSA county code 06064 as Boulder County, CO, when, as the commenter stated, SSA county code 06064 is Broomfield County, CO. As explained above, SSA county code 06064 (Broomfield County CO) is an eligible county. However, SSA county code 06060 (Boulder County, CO) is not an eligible county. Therefore, Colorado hospitals located in SSA county code 06060 (Boulder County, CO) are not qualifying hospitals under section 1109 of Public Law 111–152 using the methodology we are finalizing in this final rule. In Table 1 below, we have corrected the information that appeared in Table 2 of the supplement proposed rule.

We disagree that the hospital located in SSA county code 06500 (Pueblo County, CO) is a qualifying hospital. SSA county code 06500 (Pueblo County, CO) was not listed as an eligible county using the methodology we proposed in the supplemental proposed rule, and remains ineligible in this final rule. Therefore, IPPS hospitals located in that county are not qualifying hospitals under section 1109 of Public Law 111–152.

Comment: Commenters stated that SSA county code 43650 (Washabaugh County, SD) was incorrectly listed as a eligible county. Commenters stated that this county has been incorporated into county code 43350 (Jackson County, SD). Commenters also stated that SSA county code 49867 (South Boston City, VA) is incorporated into SSA county code 49410 (Halifax County, VA).

Response: We verified our SSA county code listing and agree with the commenters that Washabaugh County, SD and Jackson County, SD should not be listed as separate counties. We have rerun the relevant calculations for determining an eligible county using the methodology finalized in this rule, treating Washabaugh County, SD and the Jackson County, SD as a single county; the result is that Jackson County, SD remains an eligible county as proposed. Therefore, we have removed Washabaugh County, SD from the eligible county list. In addition, when we reran the relevant calculations for determining an eligible county using the methodology finalized in this rule, treating Halifax County, VA and South Boston City, VA as a single county, Halifax County remains an eligible county as proposed.

In the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we had stated that there were 3,144 counties nationwide, with 786 counties in the lowest quartile eligible to receive payments under section 1109 of the Public Law 111–152. With these changes, there are 3,142 counties, with the lowest quartile having 785.50 eligible counties, which rounds to 786 eligible counties. While the number of counties in the lowest quartile has remained the same, the removal of two counties has allowed two additional counties to be added. The additional counties added to the list are SSA county code 38060 (Crook County, OR) and SSA county code 35040 (Bottineu County, ND). We have not identified any qualifying IPPS hospitals located in Crook County, OR or in Bottineu County, ND.

Because we have replaced two counties on our list of eligible counties, we are providing the public an opportunity to notify CMS whether there are any qualifying IPPS hospitals located in either of these two newly added counties. We note that the list of eligible counties and qualifying hospitals is otherwise finalized in this rule in Tables 2 and 3 in this section IV.J. We are soliciting public input until August 30, 2010, solely on the issue of whether there are any IPPS hospitals located in Crooks County, OR and Bottineu County, ND. The public may submit input via e-mail to Nisha Bhat at *Nisha.Bhat@cms.hhs.gov.* All information must be received by August 30, 2010. If we add qualifying hospitals in these counties as a result of accurate notification from the public, we will publish a revised list of qualifying hospitals and their payment weighting factors on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/IPPS2011/list.asp#TopOfPage.*

5. Payment Determination and Distribution

As mentioned above, under section 1109(b) of Public Law 111–152, the total pool of payments available to qualifying hospitals for FY 2011 and FY 2012 is $400 million. The statute is not specific as to the timing of these payments. Because Congress has allocated a set amount ($400 million) for hospitals for FYs 2011 and 2012 under this provision, we believe it is consistent with the statute to spread these payments over the 2-year period. In the supplemental proposed rule, we proposed to distribute $150 million for FY 2011 and $250 million for FY 2012. Because this is a new policy, we proposed to distribute a smaller amount of money for the first year, $150 million for FY 2011 and gave the public an opportunity to review our policy and notify us of any possible revisions to the list of qualifying hospitals, so that we could adjust payments for FY 2012. This would ensure that we correctly identified qualifying hospitals and their proper payment amounts without exceeding the program's funding. We invited public comment to give hospitals the opportunity to request necessary changes to the qualifying hospital list for FY 2011 in order to ensure the accuracy of the qualifying hospital list based on the methodology that we proposed (and are finalizing in

this final rule). However, we proposed to identify eligible counties, qualifying hospitals, and their payment amounts under section 1109 of Public Law 111–152 only once. Because Congress allocated a specific amount of money, we proposed to identify eligible counties, qualifying hospitals, and their payment amounts once to ensure that we do not exceed the fixed amount of money and to ensure predictability of payments.

We proposed to distribute payments through the individual hospital's Medicare contractor through an annual one-time payment during each of FY 2011 and FY 2012. We believe that annual payments made by the fiscal intermediaries and MACs would be an expeditious way to give the qualifying hospitals the money allotted under section 1109 of Public Law 111–152. Alternatively, these payments could be distributed to qualifying hospitals at the time of cost report settlement for the qualifying providers' fiscal year end FY 2011 and FY 2012 cost reports. However, cost report settlement typically takes several years beyond a hospital's fiscal year end. If we distributed these additional payments at the time of cost report settlement, it may take several years until hospitals receive these additional payments. Therefore, we believe our proposal to give hospitals their section 1109 payments as annual payments during FY 2011 and FY 2012 presents the most expedient method to distribute these payments to hospitals, and is in the spirit of the intent of Congress. We welcomed public comment on our proposal to distribute $150 million in FY 2011 and $250 million in FY 2012 through an annual payment in each of those years made to the qualifying providers through their fiscal intermediary or MAC.

We proposed that qualifying hospitals report these additional payments on their Medicare hospital cost report corresponding to the appropriate cost reporting period that the hospitals receive the payments. The Medicare hospital cost report, Form 2552, has an "Other adjustment" line on Worksheet E, Part A, that can used by hospitals to report the payments received under section 1109 of Public Law 111–152. We plan to issue additional cost reporting instructions for qualifying hospitals to report these additional payments on a subscripted line of the "Other adjustment" line to identify this payment. We noted that we are requiring these payments be reported on the cost report for tracking purposes only. These additional payments will not be adjusted or settled by the fiscal intermediary or MAC on the cost report.

Comment: One commenter suggested that, for the purposes of cost reporting, payments received under the provision of section 1109 of Public Law 111–152 be reported on Worksheet S–2, instead of Worksheet E, Part A on the "other adjustment" line. The commenter recommended that these payments be reported on Worksheet S–2 so that the payments would not be mixed with the Medicare Part A settlement amounts.

Response: We proposed that hospitals report this information on the "Other adjustment" line of Worksheet E, Part A, on the Medicare hospital cost report, Form 2552, because the funding from section 1109 has been allocated from the Federal Hospital Insurance Trust Fund. Funding from the Federal Hospital Insurance Trust Fund is generally reported on Worksheet E, Part A. Therefore, we do not believe that it is appropriate to report these payments on Worksheet S–2. The funding will not be reconciled through the Medicare cost report because payments will be distributed through a one-time payment made in FY 2011 and a one-time payment made in FY 2012 to the qualifying hospitals by the Medicare contractor. Rather, hospitals will report the payments received under this provision for tracking purposes.

Comment: Several commenters disagreed with the proposal to distribute $150 million for FY 2011 and $250 million for FY 2012 and, instead, recommended that funding be distributed in equal amounts of $200 million for FY 2011 and $200 million for FY 2012. One commenter suggested that, due to the current economic conditions, $250 million be distributed for FY 2011 and $150 million for FY 2012. Several commenters requested that if hospitals are left off the list of qualifying hospitals for FY 2011 and added for FY 2012, they should be given their full share of the $400 million allotted by Congress.

Response: Section 1109(b) of the Public Law 111–152 makes available $400 million from the Federal Hospital Insurance Trust Fund to be allocated for FY 2011 and for FY 2012 for qualifying hospitals. We proposed to allocate $150 million for FY 2011 and $250 million for FY 2012 because of concerns that we might need to revise our list of qualifying hospitals after the publication of FY 2011 IPPS/LTCH PPS final rule. If we determine that we need to revise the list, we also would need to ensure that we allocated the proper amount without exceeding the program's funding. We invited public comment on the accuracy of our list of eligible counties and qualifying hospitals in those counties. As discussed earlier, based on the public comments that we received, we identified two additional qualifying hospitals. We also have added two additional eligible counties with no qualifying hospitals and are inviting public input as to whether there are qualifying hospitals located in those two new qualifying counties. Because we are allowing the public to notify us on the issue of whether our determination that there are no qualifying hospitals in the two additional eligible counties is accurate, and we want to ensure that we do not exceed the allotted amount of funding from the provision, we continue to believe it is prudent to disburse less funds in FY 2011. Therefore, we are finalizing our proposal to distribute $150 million for FY 2011 and $250 million for FY 2012 through two annual payments made by the Medicare contractors.

It was not our intention to allocate a lesser share of the $400 million to hospitals that were not on the qualifying list in this final rule, but later found to qualify. We are committed to ensuring that qualifying hospitals, regardless of when their qualification is confirmed, receive their appropriate share of the $400 million. As discussed in the supplemental proposed rule, because this is a new provision, we were uncertain as to whether we had correctly identified all of the qualifying hospitals in the eligible counties to receive money under section 1109 of the Public Law 111–152. However, based on the public comments, we believe we have been able to identify the qualifying hospitals. In the supplemental proposed rule, we proposed to make only one determination of eligible counties and qualifying hospitals for FY 2011 and FY 2012.

We have concluded that our comment period allowed the public the opportunity to comment on the accuracy of the list of eligible counties and qualifying hospitals. Therefore, after consideration of the comments we received, we are finalizing the list of the hospitals that qualify to receive their payments and their payment amounts in this final rule, with the caveat that we will accept additional public input on the limited issue of whether there are any qualifying hospitals in the two newly identified eligible counties. We also are finalizing our proposal to make only one determination of eligible counties and qualifying hospitals for FY 2011 and FY 2012, also with the caveat that we will accept additional public input on the limited issue of whether there are any qualifying hospitals in the two newly identified eligible counties. We are finalizing our proposal to

distribute $150 million for FY 2011 and $250 million for FY 2012. To the extent that there are qualifying hospitals that were not identified in this final rule after we receive any additional public input, we will review that issue in future rulemaking, and those hospitals will be eligible for their allocation of the entire $400 million.

6. Hospital Weighting Factors

Section 1109(c) of Public Law 111–152 requires that the payment amount for a qualifying hospital shall be determined "in proportion to the portion of the amount of the aggregate payments under section 1886(d) of the Social Security Act to the hospital for fiscal year 2009 bears to the sum of all such payments to all qualifying hospitals for such fiscal year." We proposed that the portion of a hospital's payment under section 1109 is based on the proportion of its IPPS operating payments made in FY 2009 under section 1886(d) of the Act relative to the total IPPS operating payments made to all qualifying hospitals in FY 2009 under section 1886(d) of the Act. These FY 2009 IPPS operating payments made under section 1886(d) of the Act include DRG and wage-adjusted payments made under the IPPS standardized amount with add-on payments for operating DSH, operating IME, operating outliers and new technology (collectively referred to in the proposed rule and this final rule as the IPPS operating payment amount). We proposed to include IME MA payments made to IPPS hospitals because these payments are made under section 1886(d) of the Act. Under 42 CFR 412.105(g) of the regulations and as implemented in Transmittal A–98–21 (Change Request 332), hospitals that are paid under the IPPS and train residents in approved GME programs may submit claims associated with MA enrollees to the fiscal intermediary or MAC for the purpose of receiving an IME payment. No IPPS operating payment or other add-on payment is made for these MA enrollees. This is consistent with how the IPPS includes these IME MA payments when adjusting for budget neutrality of the IPPS standardized amounts.

In addition, we included in the FY 2009 IPPS operating payment amount beneficiary liabilities (coinsurance, copayments, and deductibles) because the payments made under section 1886(d) of the Act "are subject to the provisions of section 1813." That is, the payment received by the hospital includes the amount paid by Medicare, as well as the amount for which the beneficiary is responsible, as set forth in section 1813 of the Act. We proposed to exclude IPPS capital payments because they are payments made under section 1886(g) of the Act. We also proposed to exclude payments for organ acquisition costs because they are payments made under section 1881(d) of the Act. In addition, we proposed to exclude payments for blood clotting factor because they are payments made under section 1886(a)(4) of the Act.

Consistent with our IPPS ratesetting process, we proposed to use the FY 2009 MedPAR inpatient claims data to determine the FY 2009 IPPS operating payments made to qualifying hospitals in order to set the ratio for determining a qualifying hospital's share of the $400 million payment under section 1109 of Public Law 111–152. Although these claim payments may be later changed and adjusted at cost report settlement, this settlement generally occurs after FY 2011 and FY 2012. Furthermore, we believe that the use of the FY 2009 MedPAR inpatient claims data is consistent with our proposal to make the payments under section 1109 of Public Law 111–152 in two annual payments in FY 2011 and FY 2012 instead of waiting for cost report settlement. Furthermore, we used MedPAR data in other areas of the IPPS, including calculating IPPS MS–DRG relative weights, budget neutrality factors, outlier thresholds, and the standardized amount. The FY 2009 MedPAR data can be ordered to allow the public to verify qualifying hospitals' FY 2009 IPPS operating payments. Interested individuals may order these files through the CMS 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, Mailstop C3–07–11, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For the supplemental proposed rule, we used the December 2009 update to the FY 2009 MedPAR claims data file (which was the latest available update to the file at that time) to determine the proposed qualifying hospitals' IPPS operating payment amounts. For this FY 2011 IPPS/LTCH PPS final rule, we used the March 2010 update to the FY 2009 MedPAR data to determine qualifying hospitals' IPPS operating payment amounts, which is used to set the hospital weighting factors for FYs 2011 and 2012.

As discussed previously in section IV.J.3. of this preamble, qualifying hospitals can include SCHs and MDHs because they meet the definition of subsection (d) hospitals. SCHs are paid in the interim (prior to cost report settlement) on a claim-by-claim basis at the amount that is the higher of the payment based on the hospital-specific rate or the IPPS Federal rate based on the standardized amount. At cost report settlement, the fiscal intermediary or MAC determines if the hospital would receive higher IPPS payments in the aggregate using the hospital's specific rate (on all claims) or the Federal rate (on all claims). The fiscal intermediary or MAC then assigns the hospital the higher payment amount (either the hospital specific rate for all claims or the Federal rate amount for all claims) for the cost reporting period. To determine the FY 2009 operating payment amount for SCHs that meet the definition of a qualifying hospital, we proposed to use the IPPS operating payment made on the Medicare IPPS claim in the FY 2009 MedPAR file rather than the SCH's final payment rate that is determined at cost report settlement. We believe this approach is consistent with the treatment of other qualifying hospitals under our proposal, and again allows for the timely distribution of funds in two annual payments, as discussed above. MDHs are paid the sum of the Federal payment amount plus 75 percent of the amount by which the hospital-specific rate exceeds the Federal payment amount. This amount is considered their IPPS operating payment reported on their Medicare IPPS claims.

In order to calculate payment amounts consistent with section 1109(c) of Public Law 111–152, we proposed to use a weighting factor for each qualifying hospital that is equal to the qualifying hospital's FY 2009 IPPS operating payment amount (as described above) divided by the sum of FY 2009 IPPS operating payment amounts for all qualifying hospitals. We believe this methodology is consistent with the requirement of section 1109(c) of Public Law 111–152, because a qualifying hospital with a larger proportion of operating payments would have a

proportionately higher weighting factor and would receive the proportionately larger share of the $400 million, while a hospital with a smaller proportion of operating payments would have a proportionately smaller weighting factor and would receive proportionately smaller shares of the $400 million. We welcomed public comment on our methodology to determine the amount of money distributed to qualifying hospitals consistent with the language in section 1109(c) of Public Law 111–152.

Comment: One commenter suggested that payments made under reasonable cost contracts under section 1876 of the Act be included in the calculation of a qualifying hospital's payment weighting factor. The commenter stated that there are a significant number of Medicare beneficiaries enrolled in these cost plans in Hawaii and that they comprise a large proportion of Hawaii hospitals' payments. Payments to hospitals are made using the Medicare fee-for-service rate or the reasonable cost for treating inpatients in these cost plans. The commenter believed that, because these hospitals are paid at the Medicare fee-for-service rate, those payments should be included in the qualifying hospitals' payment weighting factors.

Response: Section 1876 reasonable cost contracts are entered into with Medicare managed care cost plans (HMOs/CMPs) that cover Medicare-eligible beneficiaries. The commenter suggested that inpatient hospital payments for Medicare enrollees in the section 1876 cost plans that directly pay for inpatient hospital benefits should be included in the qualifying hospital's weighting factor. Section 1109(c) of Public Law 111–152 specifies that the proportion of the $400 million given to a qualifying hospital is based on the qualifying hospital's payments under section 1886(d) of the Act for FY 2009 relative to the total payments under section 1886(d) of the Act for all of the qualifying hospitals for FY 2009. Payments to hospitals that treat Medicare enrollees in these managed care cost plans that pay directly for inpatient hospital benefits are paid by the managed care cost plan under section 1876 of the Act; the payments are not under section 1886(d) of the Act. Therefore, we believe that these payments do not meet the requirement under section 1109(c) of Public Law 111–152, and we are excluding inpatient hospital payments made under section 1876 of the Act from qualifying hospitals' payment weighting factors.

Additionally, we proposed to use the FY 2009 MedPAR inpatient claims data to determine the FY 2009 IPPS operating payments to calculate the qualifying hospitals' payment weighting factors. IPPS hospitals submit these inpatient claims to receive IPPS operating payments under section 1886(d) of the Act. Because Medicare beneficiaries enrolled in these managed care cost plans have their inpatient services paid for by their cost plan under section 1876 of the Act, the MedPAR file does not have their hospital inpatient payment information. Therefore, we believe that hospital payments received for beneficiaries in section 1876 reasonable cost plans should not qualify as a "payment[ ] under section 1886(d)" of the Act for purposes of section 1109(c) of Public Law 111–152.

Comment: One commenter was concerned with the proposal to base payments on the FY 2009 MedPAR data for SCHs and MDHs. The commenter suggested that MedPAR would not accurately calculate payments for SCHs and MDHs, which are IPPS hospitals that are paid under the higher of the IPPS Federal rate or the hospital-specific rate. The commenter stated that the MedPAR file assumes that a high level of outlier payments exists for most SCHs and MDHs, and therefore disproportionately understates their actual payment, which is determined at cost report settlement. The MedPAR file contains interim payments where outlier payments may be higher or lower than the actual outlier payment amount, which is reconciled at cost report settlement. The commenter requested that CMS use the cost report to determine SCH and MDH payment weighting factors because the cost report contains the final IPPS operating payment amounts.

Response: We note that interim payments to SCH and MDHs are made on the basis of the best available data at the time and can include other interim payment amounts, such as DSH and IME. Interim payments can be adjusted and changed at cost report settlement. However, these interim payment changes are not limited to SCHs and MDHs, as IPPS hospitals that are not SCHs or MDHs receive interim payments for DSH and IME that are paid through the inpatient claim. Therefore, SCHs and MDHs are not necessarily more or less disadvantaged than other IPPS hospitals under our proposal to use inpatient claims in the MedPAR file as opposed to finalized cost reports to determine qualifying hospitals' payment weighting factors. Additionally, section 1109(a) of Public Law 111–152 requires the Secretary to make payments "to qualifying hospitals * * * for fiscal years 2011 and 2012," and section 1109(b) of Public Law 111–152 makes $400 million available for payments "for fiscal years 2011 and 2012" based on qualifying hospitals' IPPS operating payments from FY 2009. It generally takes several years to finalize hospitals' Medicare cost report. If we waited for cost report settlement to finalize interim values such as DSH, IME, and interim payment to SCHs and MDHs, we would be delaying making these additional payments well beyond FYs 2011 and 2012. As we noted in the preamble to the supplemental proposed rule (75 FR 30929), we proposed to make payments under section 1109 of Public Law 111–152 during FYs 2011 and 2012 based on available interim MedPAR data, because of this delay. Although waiting until cost reports are settled might yield somewhat more precise payment information for some qualifying hospitals receiving interim payments, including SCHs and MDHs, we believe it is in the interest of the hospitals to use the best available at this time to expedite disbursement of the funds in FY 2011 and FY 2012. We believe the FY 2009 MedPAR file contains the best data available, and using these data is the most expeditious method to determine a hospital's weighting factor and is consistent with this decision to make payments in the relevant fiscal years.

Comment: One commenter supported determining qualifying hospitals only once in FY 2011 for the purposes of making payments in FY 2011 and FY 2012. The commenter stated that this approach provides certainty to qualifying hospitals to allow them to budget for the next 2 fiscal years.

Response: We agree that finalizing the list of eligible counties and qualifying hospitals once will ease implementation of the provision and will allow hospitals to plan their budgets accordingly. As discussed earlier, we have modified our proposed approach because we have replaced two eligible counties and have not identified any qualifying IPPS hospitals located in those counties. We are allowing the public until August 30, 2010 to give input via e-mail as to whether there are any qualifying hospitals located in those two additional eligible counties. If there are any changes to the list, we will republish that information on the CMS Web site. To the extent that there are any other issues that arise after the publication of this final rule, we would consider those issues in future rulemaking.

We are finalizing our methodology to calculate the qualifying hospitals' payment weighting factors as proposed using the March 2010 update of the FY

2009 MedPAR inpatient claims information. We are finalizing our proposal to distribute $150 million for FY 2011 and $250 million for FY 2012.

7. Results

In calculating county-level Medicare Part A and B spending and after consideration of the public comments we received, we have found that there are 3,142 counties in the United States. Therefore, there are 786 counties that rank in the lowest quartile of counties with regards to adjusted Medicare Part A and Part B spending per enrollee. Of those 786 eligible counties, there are only 273 counties in which qualifying hospitals are located, using the methodology we proposed in section II.E.3. of the preamble to the supplemental proposed rule and that we are finalizing in this final rule. Using Medicare provider numbers, we identified 416 IPPS hospitals that are currently located in those eligible counties and received IPPS operating payments in FY 2009.

In accordance with our responses to the comments and our final methodology, we have set out the final list of eligible counties in Table 1 below. In addition, we have set out the final list of qualifying hospitals, location, and payment weighting factors (subject to our consideration of any comments we receive regarding whether there are any qualifying hospitals in the two newly added eligible counties) based on the March 2010 update of the FY 2009 MedPAR in Table 2 below. Finally, we have set out the payments under section 1109 by State for FY 2011 (again, subject to our consideration of any public input we receive regarding whether there are any qualifying hospitals in the two newly added eligible counties) in Table 3 below.

8. Finalization of Eligible Counties, Qualifying Hospitals and Qualifying Hospitals' Weighting Factors

We noted in the proposed rule that, based on public comments, it would be possible that we finalized a methodology to determine the list of eligible counties and hospitals that differs from our current proposal. A change in our methodology could, in turn, result in changes to the list of eligible counties or qualifying hospitals. We note again that we proposed to identify eligible counties, qualifying providers, and their payments under section 1109 of Public Law 111–152 only once in the FY 2011 IPPS/LTCH PPS final rule, and we are finalizing this proposal in this final rule. As we proposed, the methodology for determining a final list of eligible counties produced the actual list of eligible counties that are being finalized in this FY 2011 IPPS/LTCH PPS final rule and will not be updated in a future fiscal year based on updated data.

However, as discussed earlier, we replaced two counties in the eligible counties list and did not identify qualifying hospitals located in those new counties and we are seeking public input via e-mail by August 30, 2010, as to whether there are any qualifying hospitals located in those counties. If there are additional changes to our qualifying hospitals list, we will publish that information on the CMS Web site soon after August 30, 2010.

BILLING CODE 4120–01–P

Table 1:--List of Eligible Counties

County Code	County Name	State
01050	BULLOCK	ALABAMA
01400	LEE	ALABAMA
01430	MACON	ALABAMA
01590	SUMTER	ALABAMA
01650	WILCOX	ALABAMA
03010	COCHISE	ARIZONA
03040	GRAHAM	ARIZONA
03050	GREENLEE	ARIZONA
03110	SANTA CRUZ	ARIZONA
03120	YAVAPAI	ARIZONA
04030	BENTON	ARKANSAS
04070	CARROLL	ARKANSAS
04230	FRANKLIN	ARKANSAS
04240	FULTON	ARKANSAS
04340	JEFFERSON	ARKANSAS
04380	LEE	ARKANSAS
04410	LOGAN	ARKANSAS
04430	MADISON	ARKANSAS
04440	MARION	ARKANSAS
04480	MONTGOMERY	ARKANSAS
04500	NEWTON	ARKANSAS
04630	SCOTT	ARKANSAS
04640	SEARCY	ARKANSAS
04710	WASHINGTON	ARKANSAS
05110	HUMBOLDT	CALIFORNIA
05350	MODOC	CALIFORNIA
05410	PLACER	CALIFORNIA
05670	YOLO	CALIFORNIA
06010	ALAMOSA	COLORADO
06030	ARCHULETA	COLORADO
06064	BROOMFIELD	COLORADO
06070	CHAFFEE	COLORADO
06110	COSTILLA	COLORADO
06120	CROWLEY	COLORADO
06130	CUSTER	COLORADO
06160	DOLORES	COLORADO
06210	FREMONT	COLORADO
06250	GUNNISON	COLORADO
06260	HINSDALE	COLORADO
06280	JACKSON	COLORADO
06350	LAS ANIMAS	COLORADO

County Code	County Name	State
06410	MONTEZUMA	COLORADO
06530	ROUTT	COLORADO
06550	SAN JUAN	COLORADO
06590	TELLER	COLORADO
11230	CHATTAHOOCHEE	GEORGIA
11260	CLARKE	GEORGIA
11270	CLAY	GEORGIA
11360	DECATUR	GEORGIA
11430	ELBERT	GEORGIA
11510	GRADY	GEORGIA
11580	HARRIS	GEORGIA
11730	MARION	GEORGIA
11835	RANDOLPH	GEORGIA
11840	RICHMOND	GEORGIA
11881	TALIAFERRO	GEORGIA
11890	THOMAS	GEORGIA
11902	TOWNS	GEORGIA
11950	WASHINGTON	GEORGIA
12010	HAWAII	HAWAII
12020	HONOLULU	HAWAII
12040	KAUAI	HAWAII
12050	MAUI	HAWAII
13000	ADA	IDAHO
13020	BANNOCK	IDAHO
13050	BINGHAM	IDAHO
13060	BLAINE	IDAHO
13070	BOISE	IDAHO
13080	BONNER	IDAHO
13090	BONNEVILLE	IDAHO
13100	BOUNDARY	IDAHO
13130	CANYON	IDAHO
13150	CASSIA	IDAHO
13160	CLARK	IDAHO
13180	CUSTER	IDAHO
13200	FRANKLIN	IDAHO
13210	FREMONT	IDAHO
13220	GEM	IDAHO
13250	JEFFERSON	IDAHO
13260	JEROME	IDAHO
13280	LATAH	IDAHO
13310	LINCOLN	IDAHO
13320	MADISON	IDAHO
13330	MINIDOKA	IDAHO
13360	OWYHEE	IDAHO
13370	PAYETTE	IDAHO

County Code	County Name	State
13380	POWER	IDAHO
13410	TWIN FALLS	IDAHO
13430	WASHINGTON	IDAHO
14080	CASS	ILLINOIS
14150	CRAWFORD	ILLINOIS
14190	DOUGLAS	ILLINOIS
14320	EDWARDS	ILLINOIS
14600	LEE	ILLINOIS
14630	MC DONOUGH	ILLINOIS
14650	MC LEAN	ILLINOIS
14730	MENARD	ILLINOIS
14770	MORGAN	ILLINOIS
14830	PIKE	ILLINOIS
14921	SCHUYLER	ILLINOIS
14940	SCOTT	ILLINOIS
14960	STARK	ILLINOIS
14970	STEPHENSON	ILLINOIS
14981	UNION	ILLINOIS
14992	WOODFORD	ILLINOIS
15000	ADAMS	INDIANA
15060	BROWN	INDIANA
15160	DE KALB	INDIANA
15190	ELKHART	INDIANA
15230	FRANKLIN	INDIANA
15340	HUNTINGTON	INDIANA
15350	JACKSON	INDIANA
15420	KOSCIUSKO	INDIANA
15430	LAGRANGE	INDIANA
15490	MARSHALL	INDIANA
15520	MONROE	INDIANA
15560	NOBLE	INDIANA
15580	ORANGE	INDIANA
15840	WABASH	INDIANA
15890	WELLS	INDIANA
15910	WHITLEY	INDIANA
16000	ADAIR	IOWA
16020	ALLAMAKEE	IOWA
16030	APPANOOSE	IOWA
16050	BENTON	IOWA
16070	BOONE	IOWA
16100	BUENA VISTA	IOWA
16130	CARROLL	IOWA
16140	CASS	IOWA
16150	CEDAR	IOWA
16160	CERRO GORDO	IOWA

County Code	County Name	State
16170	CHEROKEE	IOWA
16190	CLARKE	IOWA
16200	CLAY	IOWA
16210	CLAYTON	IOWA
16230	CRAWFORD	IOWA
16240	DALLAS	IOWA
16250	DAVIS	IOWA
16260	DECATUR	IOWA
16270	DELAWARE	IOWA
16290	DICKINSON	IOWA
16310	EMMET	IOWA
16320	FAYETTE	IOWA
16330	FLOYD	IOWA
16340	FRANKLIN	IOWA
16360	GREENE	IOWA
16370	GRUNDY	IOWA
16380	GUTHRIE	IOWA
16400	HANCOCK	IOWA
16410	HARDIN	IOWA
16430	HENRY	IOWA
16440	HOWARD	IOWA
16450	HUMBOLDT	IOWA
16460	IDA	IOWA
16470	IOWA	IOWA
16480	JACKSON	IOWA
16490	JASPER	IOWA
16500	JEFFERSON	IOWA
16510	JOHNSON	IOWA
16520	JONES	IOWA
16530	KEOKUK	IOWA
16540	KOSSUTH	IOWA
16560	LINN	IOWA
16570	LOUISA	IOWA
16580	LUCAS	IOWA
16590	LYON	IOWA
16600	MADISON	IOWA
16610	MAHASKA	IOWA
16620	MARION	IOWA
16630	MARSHALL	IOWA
16650	MITCHELL	IOWA
16690	MUSCATINE	IOWA
16700	OBRIEN	IOWA
16710	OSCEOLA	IOWA
16730	PALO ALTO	IOWA
16740	PLYMOUTH	IOWA

County Code	County Name	State
16760	POLK	IOWA
16780	POWESHIEK	IOWA
16790	RINGGOLD	IOWA
16830	SIOUX	IOWA
16840	STORY	IOWA
16850	TAMA	IOWA
16860	TAYLOR	IOWA
16870	UNION	IOWA
16880	VAN BUREN	IOWA
16900	WARREN	IOWA
16910	WASHINGTON	IOWA
16920	WAYNE	IOWA
16930	WEBSTER	IOWA
16940	WINNEBAGO	IOWA
16950	WINNESHIEK	IOWA
16960	WOODBURY	IOWA
16970	WORTH	IOWA
17130	CLAY	KANSAS
17140	CLOUD	KANSAS
17170	COWLEY	KANSAS
17200	DICKINSON	KANSAS
17300	GEARY	KANSAS
17630	MORRIS	KANSAS
17650	NEMAHA	KANSAS
17680	NORTON	KANSAS
17710	OTTAWA	KANSAS
17780	REPUBLIC	KANSAS
17840	SALINE	KANSAS
17910	SMITH	KANSAS
17980	WABAUNSEE	KANSAS
17982	WASHINGTON	KANSAS
18050	BATH	KENTUCKY
18770	MARION	KENTUCKY
18802	MENIFEE	KENTUCKY
18860	MONTGOMERY	KENTUCKY
18971	POWELL	KENTUCKY
18987	WASHINGTON	KENTUCKY
20050	KENNEBEC	MAINE
20060	KNOX	MAINE
20070	LINCOLN	MAINE
20080	OXFORD	MAINE
20100	PISCATAQUIS	MAINE
20110	SAGADAHOC	MAINE
20130	WALDO	MAINE
23090	BENZIE	MICHIGAN

County Code	County Name	State
23200	DELTA	MICHIGAN
23210	DICKINSON	MICHIGAN
23260	GOGEBIC	MICHIGAN
23350	IRON	MICHIGAN
23440	LEELANAU	MICHIGAN
23510	MARQUETTE	MICHIGAN
23530	MECOSTA	MICHIGAN
23540	MENOMINEE	MICHIGAN
23560	MISSAUKEE	MICHIGAN
23610	NEWAYGO	MICHIGAN
23630	OCEANA	MICHIGAN
23690	OTTAWA	MICHIGAN
24020	BECKER	MINNESOTA
24050	BIG STONE	MINNESOTA
24060	BLUE EARTH	MINNESOTA
24070	BROWN	MINNESOTA
24080	CARLTON	MINNESOTA
24100	CASS	MINNESOTA
24110	CHIPPEWA	MINNESOTA
24130	CLAY	MINNESOTA
24140	CLEARWATER	MINNESOTA
24160	COTTONWOOD	MINNESOTA
24170	CROW WING	MINNESOTA
24200	DOUGLAS	MINNESOTA
24210	FARIBAULT	MINNESOTA
24220	FILLMORE	MINNESOTA
24230	FREEBORN	MINNESOTA
24250	GRANT	MINNESOTA
24270	HOUSTON	MINNESOTA
24280	HUBBARD	MINNESOTA
24310	JACKSON	MINNESOTA
24330	KANDIYOHI	MINNESOTA
24340	KITTSON	MINNESOTA
24380	LAKE OF WOODS	MINNESOTA
24390	LE SUEUR	MINNESOTA
24410	LYON	MINNESOTA
24450	MARTIN	MINNESOTA
24460	MEEKER	MINNESOTA
24480	MORRISON	MINNESOTA
24510	NICOLLET	MINNESOTA
24520	NOBLES	MINNESOTA
24550	OTTER TAIL	MINNESOTA
24560	PENNINGTON	MINNESOTA
24580	PIPESTONE	MINNESOTA
24590	POLK	MINNESOTA

County Code	County Name	State
24600	POPE	MINNESOTA
24620	RED LAKE	MINNESOTA
24630	REDWOOD	MINNESOTA
24640	RENVILLE	MINNESOTA
24650	RICE	MINNESOTA
24660	ROCK	MINNESOTA
24670	ROSEAU	MINNESOTA
24720	STEARNS	MINNESOTA
24730	STEELE	MINNESOTA
24750	SWIFT	MINNESOTA
24770	TRAVERSE	MINNESOTA
24780	WABASHA	MINNESOTA
24790	WADENA	MINNESOTA
24800	WASECA	MINNESOTA
24820	WATONWAN	MINNESOTA
24830	WILKIN	MINNESOTA
24840	WINONA	MINNESOTA
25060	CALHOUN	MISSISSIPPI
25350	LAFAYETTE	MISSISSIPPI
25430	LOWNDES	MISSISSIPPI
25510	NOXUBEE	MISSISSIPPI
25520	OKTIBBEHA	MISSISSIPPI
25790	WINSTON	MISSISSIPPI
26040	BARRY	MISSOURI
26090	BOONE	MISSOURI
26190	CEDAR	MISSOURI
26210	CHRISTIAN	MISSOURI
26260	COOPER	MISSOURI
26280	DADE	MISSOURI
26330	DOUGLAS	MISSOURI
26380	GREENE	MISSOURI
26450	HOWELL	MISSOURI
26520	LACLEDE	MISSOURI
26740	OREGON	MISSOURI
26751	OZARK	MISSOURI
26790	PETTIS	MISSOURI
26821	POLK	MISSOURI
26990	VERNON	MISSOURI
26994	WEBSTER	MISSOURI
26996	WRIGHT	MISSOURI
27030	BROADWATER	MONTANA
27040	CARBON	MONTANA
27050	CARTER	MONTANA
27080	CUSTER	MONTANA
27090	DANIELS	MONTANA

County Code	County Name	State
27100	DAWSON	MONTANA
27120	FALLON	MONTANA
27130	FERGUS	MONTANA
27140	FLATHEAD	MONTANA
27150	GALLATIN	MONTANA
27160	GARFIELD	MONTANA
27180	GOLDEN VALLEY	MONTANA
27190	GRANITE	MONTANA
27210	JEFFERSON	MONTANA
27220	JUDITH BASIN	MONTANA
27240	LEWIS AND CLARK	MONTANA
27260	LINCOLN	MONTANA
27270	MCCONE	MONTANA
27280	MADISON	MONTANA
27310	MISSOULA	MONTANA
27340	PETROLEUM	MONTANA
27350	PHILLIPS	MONTANA
27370	POWDER RIVER	MONTANA
27380	POWELL	MONTANA
27390	PRAIRIE	MONTANA
27400	RAVALLI	MONTANA
27410	RICHLAND	MONTANA
27430	ROSEBUD	MONTANA
27440	SANDERS	MONTANA
27450	SHERIDAN	MONTANA
27460	SILVER BOW	MONTANA
27470	STILLWATER	MONTANA
27480	SWEET GRASS	MONTANA
27490	TETON	MONTANA
27510	TREASURE	MONTANA
27520	VALLEY	MONTANA
27530	WHEATLAND	MONTANA
27540	WIBAUX	MONTANA
27550	YELLOWSTONE	MONTANA
28030	BANNER	NEBRASKA
28050	BOONE	NEBRASKA
28060	BOX BUTTE	NEBRASKA
28090	BUFFALO	NEBRASKA
28110	BUTLER	NEBRASKA
28130	CEDAR	NEBRASKA
28160	CHEYENNE	NEBRASKA
28190	CUMING	NEBRASKA
28210	DAKOTA	NEBRASKA
28220	DAWES	NEBRASKA
28240	DEUEL	NEBRASKA

County Code	County Name	State
28250	DIXON	NEBRASKA
28320	FURNAS	NEBRASKA
28330	GAGE	NEBRASKA
28350	GARFIELD	NEBRASKA
28360	GOSPER	NEBRASKA
28370	GRANT	NEBRASKA
28400	HAMILTON	NEBRASKA
28420	HAYES	NEBRASKA
28430	HITCHCOCK	NEBRASKA
28450	HOOKER	NEBRASKA
28470	JEFFERSON	NEBRASKA
28480	JOHNSON	NEBRASKA
28490	KEARNEY	NEBRASKA
28510	KEYA PAHA	NEBRASKA
28530	KNOX	NEBRASKA
28560	LOGAN	NEBRASKA
28570	LOUP	NEBRASKA
28580	MC PHERSON	NEBRASKA
28590	MADISON	NEBRASKA
28600	MERRICK	NEBRASKA
28610	MORRILL	NEBRASKA
28670	PERKINS	NEBRASKA
28700	PLATTE	NEBRASKA
28720	RED WILLOW	NEBRASKA
28780	SCOTT BLUFF	NEBRASKA
28800	SHERIDAN	NEBRASKA
28820	SIOUX	NEBRASKA
28830	STANTON	NEBRASKA
28850	THOMAS	NEBRASKA
28890	WAYNE	NEBRASKA
29050	EUREKA	NEVADA
30010	CARROLL	NEW HAMPSHIRE
30090	SULLIVAN	NEW HAMPSHIRE
32000	BERNALILLO	NEW MEXICO
32010	CATRON	NEW MEXICO
32025	CIBOLA	NEW MEXICO
32030	COLFAX	NEW MEXICO
32050	DE BACA	NEW MEXICO
32060	DONA ANA	NEW MEXICO
32080	GRANT	NEW MEXICO
32090	GUADALUPE	NEW MEXICO
32100	HARDING	NEW MEXICO
32110	HIDALGO	NEW MEXICO
32130	LINCOLN	NEW MEXICO
32131	LOS ALAMOS	NEW MEXICO

County Code	County Name	State
32140	LUNA	NEW MEXICO
32160	MORA	NEW MEXICO
32170	OTERO	NEW MEXICO
32180	QUAY	NEW MEXICO
32190	RIO ARRIBA	NEW MEXICO
32210	SANDOVAL	NEW MEXICO
32230	SAN MIGUEL	NEW MEXICO
32240	SANTA FE	NEW MEXICO
32250	SIERRA	NEW MEXICO
32260	SOCORRO	NEW MEXICO
32270	TAOS	NEW MEXICO
32280	TORRANCE	NEW MEXICO
32300	VALENCIA	NEW MEXICO
33010	ALLEGANY	NEW YORK
33030	BROOME	NEW YORK
33040	CATTARAUGUS	NEW YORK
33050	CAYUGA	NEW YORK
33060	CHAUTAUQUA	NEW YORK
33070	CHEMUNG	NEW YORK
33080	CHENANGO	NEW YORK
33210	CORTLAND	NEW YORK
33260	ESSEX	NEW YORK
33270	FRANKLIN	NEW YORK
33280	FULTON	NEW YORK
33310	HAMILTON	NEW YORK
33330	JEFFERSON	NEW YORK
33340	LEWIS	NEW YORK
33360	MADISON	NEW YORK
33380	MONTGOMERY	NEW YORK
33510	ONEIDA	NEW YORK
33520	ONONDAGA	NEW YORK
33530	ONTARIO	NEW YORK
33550	ORLEANS	NEW YORK
33570	OTSEGO	NEW YORK
33630	ST. LAWRENCE	NEW YORK
33640	SARATOGA	NEW YORK
33650	SCHENECTADY	NEW YORK
33660	SCHOHARIE	NEW YORK
33670	SCHUYLER	NEW YORK
33680	SENECA	NEW YORK
33690	STEUBEN	NEW YORK
33720	TIOGA	NEW YORK
33730	TOMPKINS	NEW YORK
33750	WARREN	NEW YORK
33760	WASHINGTON	NEW YORK

County Code	County Name	State
33770	WAYNE	NEW YORK
33900	WYOMING	NEW YORK
33910	YATES	NEW YORK
34040	ASHE	NORTH CAROLINA
34160	CASWELL	NORTH CAROLINA
34190	CHEROKEE	NORTH CAROLINA
34200	CHOWAN	NORTH CAROLINA
34210	CLAY	NORTH CAROLINA
34370	GRAHAM	NORTH CAROLINA
34380	GRANVILLE	NORTH CAROLINA
34490	JACKSON	NORTH CAROLINA
34550	MC DOWELL	NORTH CAROLINA
34560	MACON	NORTH CAROLINA
34600	MITCHELL	NORTH CAROLINA
34710	PERQUIMANS	NORTH CAROLINA
34720	PERSON	NORTH CAROLINA
34740	POLK	NORTH CAROLINA
34870	TRANSYLVANIA	NORTH CAROLINA
34880	TYRRELL	NORTH CAROLINA
34900	VANCE	NORTH CAROLINA
34920	WARREN	NORTH CAROLINA
34981	YANCEY	NORTH CAROLINA
35010	BARNES	NORTH DAKOTA
35030	BILLINGS	NORTH DAKOTA
35040	BOTTINEAU	NORTH DAKOTA
35060	BURKE	NORTH DAKOTA
35070	BURLEIGH	NORTH DAKOTA
35080	CASS	NORTH DAKOTA
35090	CAVALIER	NORTH DAKOTA
35100	DICKEY	NORTH DAKOTA
35110	DIVIDE	NORTH DAKOTA
35120	DUNN	NORTH DAKOTA
35130	EDDY	NORTH DAKOTA
35140	EMMONS	NORTH DAKOTA
35150	FOSTER	NORTH DAKOTA
35160	GOLDEN VALLEY	NORTH DAKOTA
35180	GRANT	NORTH DAKOTA
35190	GRIGGS	NORTH DAKOTA
35200	HETTINGER	NORTH DAKOTA
35210	KIDDER	NORTH DAKOTA
35220	LA MOURE	NORTH DAKOTA
35230	LOGAN	NORTH DAKOTA
35240	MCHENRY	NORTH DAKOTA
35250	MCINTOSH	NORTH DAKOTA
35270	MCLEAN	NORTH DAKOTA

County Code	County Name	State
35280	MERCER	NORTH DAKOTA
35290	MORTON	NORTH DAKOTA
35300	MOUNTRAIL	NORTH DAKOTA
35320	OLIVER	NORTH DAKOTA
35330	PEMBINA	NORTH DAKOTA
35350	RAMSEY	NORTH DAKOTA
35370	RENVILLE	NORTH DAKOTA
35380	RICHLAND	NORTH DAKOTA
35410	SHERIDAN	NORTH DAKOTA
35440	STARK	NORTH DAKOTA
35450	STEELE	NORTH DAKOTA
35460	STUTSMAN	NORTH DAKOTA
35470	TOWNER	NORTH DAKOTA
35480	TRAILL	NORTH DAKOTA
35490	WALSH	NORTH DAKOTA
35500	WARD	NORTH DAKOTA
35510	WELLS	NORTH DAKOTA
35520	WILLIAMS	NORTH DAKOTA
36020	ASHLAND	OHIO
36390	HOLMES	OHIO
37520	NOWATA	OKLAHOMA
37730	WASHINGTON	OKLAHOMA
38000	BAKER	OREGON
38010	BENTON	OREGON
38020	CLACKAMAS	OREGON
38060	CROOK	OREGON
38080	DESCHUTES	OREGON
38100	GILLIAM	OREGON
38130	HOOD RIVER	OREGON
38150	JEFFERSON	OREGON
38170	KLAMATH	OREGON
38180	LAKE	OREGON
38200	LINCOLN	OREGON
38220	MALHEUR	OREGON
38230	MARION	OREGON
38250	MULTNOMAH	OREGON
38260	POLK	OREGON
38270	SHERMAN	OREGON
38290	UMATILLA	OREGON
38300	UNION	OREGON
38320	WASCO	OREGON
38330	WASHINGTON	OREGON
38340	WHEELER	OREGON
39000	ADAMS	PENNSYLVANIA
39130	BRADFORD	PENNSYLVANIA

County Code	County Name	State
39200	CENTRE	PENNSYLVANIA
39240	CLINTON	PENNSYLVANIA
39440	LANCASTER	PENNSYLVANIA
39460	LEBANON	PENNSYLVANIA
39510	LYCOMING	PENNSYLVANIA
39640	POTTER	PENNSYLVANIA
39690	SULLIVAN	PENNSYLVANIA
39710	TIOGA	PENNSYLVANIA
39720	UNION	PENNSYLVANIA
42000	ABBEVILLE	SOUTH CAROLINA
42230	GREENWOOD	SOUTH CAROLINA
42320	MCCORMICK	SOUTH CAROLINA
42400	SALUDA	SOUTH CAROLINA
43010	AURORA	SOUTH DAKOTA
43020	BEADLE	SOUTH DAKOTA
43030	BENNETT	SOUTH DAKOTA
43040	BON HOMME	SOUTH DAKOTA
43050	BROOKINGS	SOUTH DAKOTA
43060	BROWN	SOUTH DAKOTA
43070	BRULE	SOUTH DAKOTA
43090	BUTTE	SOUTH DAKOTA
43100	CAMPBELL	SOUTH DAKOTA
43110	CHARLES MIX	SOUTH DAKOTA
43120	CLARK	SOUTH DAKOTA
43130	CLAY	SOUTH DAKOTA
43140	CODINGTON	SOUTH DAKOTA
43150	CORSON	SOUTH DAKOTA
43160	CUSTER	SOUTH DAKOTA
43170	DAVISON	SOUTH DAKOTA
43220	EDMUNDS	SOUTH DAKOTA
43230	FALL RIVER	SOUTH DAKOTA
43250	GRANT	SOUTH DAKOTA
43270	HAAKON	SOUTH DAKOTA
43280	HAMLIN	SOUTH DAKOTA
43290	HAND	SOUTH DAKOTA
43300	HANSON	SOUTH DAKOTA
43320	HUGHES	SOUTH DAKOTA
43330	HUTCHINSON	SOUTH DAKOTA
43340	HYDE	SOUTH DAKOTA
43350	JACKSON	SOUTH DAKOTA
43360	JERAULD	SOUTH DAKOTA
43370	JONES	SOUTH DAKOTA
43380	KINGSBURY	SOUTH DAKOTA
43390	LAKE	SOUTH DAKOTA
43400	LAWRENCE	SOUTH DAKOTA

County Code	County Name	State
43410	LINCOLN	SOUTH DAKOTA
43420	LYMAN	SOUTH DAKOTA
43430	MC COOK	SOUTH DAKOTA
43440	MC PHERSON	SOUTH DAKOTA
43450	MARSHALL	SOUTH DAKOTA
43460	MEADE	SOUTH DAKOTA
43470	MELLETTE	SOUTH DAKOTA
43490	MINNEHAHA	SOUTH DAKOTA
43500	MOODY	SOUTH DAKOTA
43510	PENNINGTON	SOUTH DAKOTA
43520	PERKINS	SOUTH DAKOTA
43540	ROBERTS	SOUTH DAKOTA
43550	SANBORN	SOUTH DAKOTA
43580	STANLEY	SOUTH DAKOTA
43590	SULLY	SOUTH DAKOTA
43610	TRIPP	SOUTH DAKOTA
43620	TURNER	SOUTH DAKOTA
43630	UNION	SOUTH DAKOTA
43640	WALWORTH	SOUTH DAKOTA
43670	YANKTON	SOUTH DAKOTA
45200	BREWSTER	TEXAS
45361	CROCKETT	TEXAS
45552	GILLESPIE	TEXAS
45662	HUDSPETH	TEXAS
45762	LOVING	TEXAS
45793	MENARD	TEXAS
45831	OCHILTREE	TEXAS
45861	PRESIDIO	TEXAS
45912	TERRELL	TEXAS
45946	VAL VERDE	TEXAS
45952	WASHINGTON	TEXAS
46010	BOX ELDER	UTAH
46020	CACHE	UTAH
46040	DAGGETT	UTAH
46050	DAVIS	UTAH
46060	DUCHESNE	UTAH
46080	GARFIELD	UTAH
46090	GRAND	UTAH
46100	IRON	UTAH
46120	KANE	UTAH
46130	MILLARD	UTAH
46140	MORGAN	UTAH
46150	PIUTE	UTAH
46160	RICH	UTAH
46200	SEVIER	UTAH

County Code	County Name	State
46210	SUMMIT	UTAH
46230	UINTAH	UTAH
46250	WASATCH	UTAH
46270	WAYNE	UTAH
47000	ADDISON	VERMONT
47020	CALEDONIA	VERMONT
47040	ESSEX	VERMONT
47070	LAMOILLE	VERMONT
47090	ORLEANS	VERMONT
47110	WASHINGTON	VERMONT
47120	WINDHAM	VERMONT
49030	AMELIA	VIRGINIA
49050	APPOMATTOX	VIRGINIA
49070	AUGUSTA	VIRGINIA
49088	BEDFORD CITY	VIRGINIA
49090	BEDFORD	VIRGINIA
49110	BOTETOURT	VIRGINIA
49120	BRUNSWICK	VIRGINIA
49141	BUENA VISTA CITY	VIRGINIA
49150	CAMPBELL	VIRGINIA
49170	CARROLL	VIRGINIA
49180	CHARLES CITY	VIRGINIA
49190	CHARLOTTE	VIRGINIA
49200	CHESTERFIELD	VIRGINIA
49220	CRAIG	VIRGINIA
49240	CUMBERLAND	VIRGINIA
49241	DANVILLE CITY	VIRGINIA
49260	DINWIDDIE	VIRGINIA
49310	FLOYD	VIRGINIA
49320	FLUVANNA	VIRGINIA
49328	FRANKLIN CITY	VIRGINIA
49330	FRANKLIN	VIRGINIA
49343	GALAX CITY	VIRGINIA
49360	GLOUCESTER	VIRGINIA
49370	GOOCHLAND	VIRGINIA
49380	GRAYSON	VIRGINIA
49400	GREENSVILLE	VIRGINIA
49410	HALIFAX	VIRGINIA
49411	HAMPTON CITY	VIRGINIA
49421	HARRISONBURG CITY	VIRGINIA
49440	HENRY	VIRGINIA
49460	ISLE OF WIGHT	VIRGINIA
49470	JAMES CITY	VIRGINIA
49510	LANCASTER	VIRGINIA
49522	LEXINGTON CITY	VIRGINIA

County Code	County Name	State
49550	LUNENBURG	VIRGINIA
49551	LYNCHBURG CITY	VIRGINIA
49560	MADISON	VIRGINIA
49561	MARTINSVILLE CITY	VIRGINIA
49570	MATHEWS	VIRGINIA
49580	MECKLENBURG	VIRGINIA
49590	MIDDLESEX	VIRGINIA
49600	MONTGOMERY	VIRGINIA
49622	NEWPORT NEWS CITY	VIRGINIA
49660	NORTHUMBERLND	VIRGINIA
49670	NOTTOWAY	VIRGINIA
49710	PITTSYLVANIA	VIRGINIA
49712	POQUOSON	VIRGINIA
49720	POWHATAN	VIRGINIA
49730	PRINCE EDWARD	VIRGINIA
49780	RAPPAHANNOCK	VIRGINIA
49800	ROANOKE	VIRGINIA
49801	ROANOKE CITY	VIRGINIA
49810	ROCKBRIDGE	VIRGINIA
49820	ROCKINGHAM	VIRGINIA
49838	SALEM CITY	VIRGINIA
49850	SHENANDOAH	VIRGINIA
49860	SMYTH	VIRGINIA
49870	SOUTHAMPTON	VIRGINIA
49891	STAUNTON CITY	VIRGINIA
49900	SURRY	VIRGINIA
49910	SUSSEX	VIRGINIA
49950	WASHINGTON	VIRGINIA
49961	WILLIAMSBURG CITY	VIRGINIA
49962	WINCHESTER CITY	VIRGINIA
49980	WYTHE	VIRGINIA
49981	YORK	VIRGINIA
50030	CHELAN	WASHINGTON
50040	CLALLAM	WASHINGTON
50050	CLARK	WASHINGTON
50100	FRANKLIN	WASHINGTON
50140	ISLAND	WASHINGTON
50180	KITTITAS	WASHINGTON
50190	KLICKITAT	WASHINGTON
50230	OKANOGAN	WASHINGTON
50270	SAN JUAN	WASHINGTON
50330	THURSTON	WASHINGTON
50340	WAHKIAKUM	WASHINGTON
50350	WALLA WALLA	WASHINGTON
50380	YAKIMA	WASHINGTON

County Code	County Name	State
51030	BRAXTON	WEST VIRGINIA
51110	GRANT	WEST VIRGINIA
51150	HARDY	WEST VIRGINIA
51350	PENDLETON	WEST VIRGINIA
51430	ROANE	WEST VIRGINIA
51480	UPSHUR	WEST VIRGINIA
51510	WETZEL	WEST VIRGINIA
52020	BARRON	WISCONSIN
52030	BAYFIELD	WISCONSIN
52040	BROWN	WISCONSIN
52050	BUFFALO	WISCONSIN
52060	BURNETT	WISCONSIN
52070	CALUMET	WISCONSIN
52080	CHIPPEWA	WISCONSIN
52100	COLUMBIA	WISCONSIN
52110	CRAWFORD	WISCONSIN
52130	DODGE	WISCONSIN
52140	DOOR	WISCONSIN
52160	DUNN	WISCONSIN
52170	EAU CLAIRE	WISCONSIN
52180	FLORENCE	WISCONSIN
52190	FOND DU LAC	WISCONSIN
52200	FOREST	WISCONSIN
52220	GREEN	WISCONSIN
52230	GREEN LAKE	WISCONSIN
52240	IOWA	WISCONSIN
52250	IRON	WISCONSIN
52260	JACKSON	WISCONSIN
52270	JEFFERSON	WISCONSIN
52280	JUNEAU	WISCONSIN
52300	KEWAUNEE	WISCONSIN
52310	LA CROSSE	WISCONSIN
52330	LANGLADE	WISCONSIN
52340	LINCOLN	WISCONSIN
52350	MANITOWOC	WISCONSIN
52360	MARATHON	WISCONSIN
52370	MARINETTE	WISCONSIN
52380	MARQUETTE	WISCONSIN
52400	MONROE	WISCONSIN
52410	OCONTO	WISCONSIN
52420	ONEIDA	WISCONSIN
52430	OUTAGAMIE	WISCONSIN
52440	OZAUKEE	WISCONSIN
52460	PIERCE	WISCONSIN
52470	POLK	WISCONSIN

County Code	County Name	State
52480	PORTAGE	WISCONSIN
52510	RICHLAND	WISCONSIN
52520	ROCK	WISCONSIN
52530	RUSK	WISCONSIN
52550	SAUK	WISCONSIN
52560	SAWYER	WISCONSIN
52570	SHAWANO	WISCONSIN
52580	SHEBOYGAN	WISCONSIN
52590	TAYLOR	WISCONSIN
52600	TREMPEALEAU	WISCONSIN
52610	VERNON	WISCONSIN
52620	VILAS	WISCONSIN
52640	WASHBURN	WISCONSIN
52670	WAUPACA	WISCONSIN
52680	WAUSHARA	WISCONSIN
52690	WINNEBAGO	WISCONSIN
52700	WOOD	WISCONSIN
53010	BIG HORN	WYOMING
53050	CROOK	WYOMING
53070	GOSHEN	WYOMING
53090	JOHNSON	WYOMING
53120	NATRONA	WYOMING
53140	PARK	WYOMING
53160	SHERIDAN	WYOMING
53220	WESTON	WYOMING

Table 2.--List of Qualifying Hospitals, Location, and Payment Weighting Factor

Provider Number	SSACD	County Name	State	Payment Weight Factor
010029	01400	LEE	ALABAMA	0.00612
010102	01650	WILCOX	ALABAMA	0.00007
010110	01050	BULLOCK	ALABAMA	0.00025
010138	01590	SUMTER	ALABAMA	0.00012
030007	03120	YAVAPAI	ARIZONA	0.00274
030012	03120	YAVAPAI	ARIZONA	0.00474
030043	03010	COCHISE	ARIZONA	0.00179
030068	03040	GRAHAM	ARIZONA	0.00067
030118	03120	YAVAPAI	ARIZONA	0.00097
040001	04030	BENTON	ARKANSAS	0.00069
040004	04710	WASHINGTON	ARKANSAS	0.00603
040010	04030	BENTON	ARKANSAS	0.00295
040022	04710	WASHINGTON	ARKANSAS	0.00546
040071	04340	JEFFERSON	ARKANSAS	0.00489
040152	04710	WASHINGTON	ARKANSAS	0.00003
050006	05110	HUMBOLDT	CALIFORNIA	0.00441
050028	05110	HUMBOLDT	CALIFORNIA	0.00074
050127	05670	YOLO	CALIFORNIA	0.00110
050309	05410	PLACER	CALIFORNIA	0.00559
050498	05410	PLACER	CALIFORNIA	0.00177
050537	05670	YOLO	CALIFORNIA	0.00079
060008	06010	ALAMOSA	COLORADO	0.00081
060016	06210	FREMONT	COLORADO	0.00073
060049	06530	ROUTT	COLORADO	0.00039
110006	11260	CLARKE	GEORGIA	0.00302
110026	11430	ELBERT	GEORGIA	0.00039
110028	11840	RICHMOND	GEORGIA	0.01093
110034	11840	RICHMOND	GEORGIA	0.00952
110038	11890	THOMAS	GEORGIA	0.00436
110039	11840	RICHMOND	GEORGIA	0.00134
110074	11260	CLARKE	GEORGIA	0.00803
110086	11950	WASHINGTON	GEORGIA	0.00057
110121	11510	GRADY	GEORGIA	0.00026
110132	11360	DECATUR	GEORGIA	0.00062
110177	11840	RICHMOND	GEORGIA	0.00522
110231	11260	CLARKE	GEORGIA	0.00004
120001	12020	HONOLULU	HAWAII	0.01101
120002	12050	MAUI	HAWAII	0.00357
120004	12020	HONOLULU	HAWAII	0.00093
120005	12010	HAWAII	HAWAII	0.00235
120006	12020	HONOLULU	HAWAII	0.00244
120007	12020	HONOLULU	HAWAII	0.00368

Provider Number	SSACD	County Name	State	Payment Weight Factor
120010	12020	HONOLULU	HAWAII	0.00233
120011	12020	HONOLULU	HAWAII	0.00053
120014	12040	KAUAI	HAWAII	0.00109
120019	12010	HAWAII	HAWAII	0.00060
120022	12020	HONOLULU	HAWAII	0.00383
120026	12020	HONOLULU	HAWAII	0.00290
120027	12020	HONOLULU	HAWAII	0.00189
120028	12010	HAWAII	HAWAII	0.00039
130002	13410	TWIN FALLS	IDAHO	0.00293
130006	13000	ADA	IDAHO	0.00691
130007	13000	ADA	IDAHO	0.00595
130013	13130	CANYON	IDAHO	0.00124
130014	13130	CANYON	IDAHO	0.00100
130018	13090	BONNEVILLE	IDAHO	0.00385
130024	13080	BONNER	IDAHO	0.00058
130025	13320	MADISON	IDAHO	0.00056
130028	13020	BANNOCK	IDAHO	0.00309
130063	13000	ADA	IDAHO	0.00009
130065	13090	BONNEVILLE	IDAHO	0.00034
130067	13050	BINGHAM	IDAHO	0.00002
130069	13000	ADA	IDAHO	0.00002
130070	13000	ADA	IDAHO	0.00006
140012	14600	LEE	ILLINOIS	0.00132
140058	14770	MORGAN	ILLINOIS	0.00149
140089	14630	MC DONOUGH	ILLINOIS	0.00087
140127	14650	MC LEAN	ILLINOIS	0.00346
140160	14970	STEPHENSON	ILLINOIS	0.00196
140162	14650	MC LEAN	ILLINOIS	0.00241
150018	15190	ELKHART	INDIANA	0.00579
150026	15190	ELKHART	INDIANA	0.00216
150045	15160	DE KALB	INDIANA	0.00036
150051	15520	MONROE	INDIANA	0.00560
150065	15350	JACKSON	INDIANA	0.00120
150075	15890	WELLS	INDIANA	0.00079
150076	15490	MARSHALL	INDIANA	0.00081
150091	15340	HUNTINGTON	INDIANA	0.00040
150101	15910	WHITLEY	INDIANA	0.00032
150133	15420	KOSCIUSKO	INDIANA	0.00110
150146	15560	NOBLE	INDIANA	0.00047
150164	15520	MONROE	INDIANA	0.00087
160001	16630	MARSHALL	IOWA	0.00112
160005	16130	CARROLL	IOWA	0.00074
160013	16690	MUSCATINE	IOWA	0.00047
160016	16930	WEBSTER	IOWA	0.00285

Provider Number	SSACD	County Name	State	Payment Weight Factor
160024	16760	POLK	IOWA	0.00322
160029	16510	JOHNSON	IOWA	0.00340
160030	16840	STORY	IOWA	0.00317
160032	16490	JASPER	IOWA	0.00066
160045	16560	LINN	IOWA	0.00528
160058	16510	JOHNSON	IOWA	0.01587
160064	16160	CERRO GORDO	IOWA	0.00666
160079	16560	LINN	IOWA	0.00389
160082	16760	POLK	IOWA	0.01130
160083	16760	POLK	IOWA	0.01407
160101	16760	POLK	IOWA	0.00034
160112	16200	CLAY	IOWA	0.00106
160124	16290	DICKINSON	IOWA	0.00050
160146	16960	WOODBURY	IOWA	0.00246
160147	16780	POWESHIEK	IOWA	0.00062
160153	16960	WOODBURY	IOWA	0.00519
160156	16560	LINN	IOWA	0.00004
170012	17840	SALINE	KANSAS	0.00342
170074	17300	GEARY	KANSAS	0.00047
170150	17170	COWLEY	KANSAS	0.00032
170187	17840	SALINE	KANSAS	0.00030
180024	18770	MARION	KENTUCKY	0.00058
180064	18860	MONTGOMERY	KENTUCKY	0.00064
200002	20070	LINCOLN	MAINE	0.00079
200032	20080	OXFORD	MAINE	0.00078
200039	20050	KENNEBEC	MAINE	0.00474
200041	20050	KENNEBEC	MAINE	0.00077
200063	20060	KNOX	MAINE	0.00197
230003	23690	OTTAWA	MICHIGAN	0.00053
230054	23510	MARQUETTE	MICHIGAN	0.00516
230055	23210	DICKINSON	MICHIGAN	0.00121
230072	23690	OTTAWA	MICHIGAN	0.00195
230093	23530	MECOSTA	MICHIGAN	0.00046
230101	23200	DELTA	MICHIGAN	0.00079
230106	23610	NEWAYGO	MICHIGAN	0.00071
230174	23690	OTTAWA	MICHIGAN	0.00042
240022	24520	NOBLES	MINNESOTA	0.00036
240030	24200	DOUGLAS	MINNESOTA	0.00174
240036	24720	STEARNS	MINNESOTA	0.01173
240043	24230	FREEBORN	MINNESOTA	0.00090
240044	24840	WINONA	MINNESOTA	0.00068
240052	24550	OTTER TAIL	MINNESOTA	0.00095
240069	24730	STEELE	MINNESOTA	0.00062
240071	24650	RICE	MINNESOTA	0.00059

Provider Number	SSACD	County Name	State	Payment Weight Factor
240075	24170	CROW WING	MINNESOTA	0.00239
240088	24330	KANDIYOHI	MINNESOTA	0.00126
240093	24060	BLUE EARTH	MINNESOTA	0.00377
240101	24020	BECKER	MINNESOTA	0.00068
240166	24450	MARTIN	MINNESOTA	0.00084
250027	25790	WINSTON	MISSISSIPPI	0.00016
250034	25350	LAFAYETTE	MISSISSIPPI	0.00455
250050	25520	OKTIBBEHA	MISSISSIPPI	0.00077
250100	25430	LOWNDES	MISSISSIPPI	0.00294
250112	25060	CALHOUN	MISSISSIPPI	0.00010
260004	26260	COOPER	MISSOURI	0.00013
260009	26790	PETTIS	MISSOURI	0.00230
260040	26380	GREENE	MISSOURI	0.01099
260059	26520	LACLEDE	MISSOURI	0.00085
260061	26990	VERNON	MISSOURI	0.00035
260065	26380	GREENE	MISSOURI	0.01275
260068	26090	BOONE	MISSOURI	0.00858
260078	26450	HOWELL	MISSOURI	0.00162
260141	26090	BOONE	MISSOURI	0.00922
260178	26090	BOONE	MISSOURI	0.00154
260195	26821	POLK	MISSOURI	0.00109
260207	26380	GREENE	MISSOURI	0.00037
260221	26380	GREENE	MISSOURI	0.00002
270002	27080	CUSTER	MONTANA	0.00055
270003	27240	LEWIS AND CLARK	MONTANA	0.00144
270004	27550	YELLOWSTONE	MONTANA	0.00577
270014	27310	MISSOULA	MONTANA	0.00413
270017	27460	SILVER BOW	MONTANA	0.00187
270023	27310	MISSOULA	MONTANA	0.00183
270049	27550	YELLOWSTONE	MONTANA	0.00565
270051	27140	FLATHEAD	MONTANA	0.00273
270057	27150	GALLATIN	MONTANA	0.00142
270087	27140	FLATHEAD	MONTANA	0.00021
280009	28090	BUFFALO	NEBRASKA	0.00420
280061	28780	SCOTT BLUFF	NEBRASKA	0.00251
280111	28700	PLATTE	NEBRASKA	0.00078
280125	28590	MADISON	NEBRASKA	0.00263
320001	32000	BERNALILLO	NEW MEXICO	0.00728
320002	32240	SANTA FE	NEW MEXICO	0.00391
320003	32230	SAN MIGUEL	NEW MEXICO	0.00066
320004	32170	OTERO	NEW MEXICO	0.00173
320009	32000	BERNALILLO	NEW MEXICO	0.00270
320011	32190	RIO ARRIBA	NEW MEXICO	0.00059
320013	32270	TAOS	NEW MEXICO	0.00087

Provider Number	SSACD	County Name	State	Payment Weight Factor
320014	32140	LUNA	NEW MEXICO	0.00063
320016	32080	GRANT	NEW MEXICO	0.00087
320017	32000	BERNALILLO	NEW MEXICO	0.00062
320018	32060	DONA ANA	NEW MEXICO	0.00396
320021	32000	BERNALILLO	NEW MEXICO	0.00964
320033	32131	LOS ALAMOS	NEW MEXICO	0.00058
320037	32025	CIBOLA	NEW MEXICO	0.00021
320057	32240	SANTA FE	NEW MEXICO	0.00006
320058	32170	OTERO	NEW MEXICO	0.00002
320067	32090	GUADALUPE	NEW MEXICO	0.00015
320069	32030	COLFAX	NEW MEXICO	0.00049
320070	32025	CIBOLA	NEW MEXICO	0.00010
320074	32000	BERNALILLO	NEW MEXICO	0.00048
320083	32000	BERNALILLO	NEW MEXICO	0.00248
320085	32060	DONA ANA	NEW MEXICO	0.00347
320087	32240	SANTA FE	NEW MEXICO	0.00011
320088	32060	DONA ANA	NEW MEXICO	0.00017
330008	33900	WYOMING	NEW YORK	0.00049
330010	33380	MONTGOMERY	NEW YORK	0.00001
330011	33030	BROOME	NEW YORK	0.00332
330030	33770	WAYNE	NEW YORK	0.00086
330033	33080	CHENANGO	NEW YORK	0.00071
330044	33510	ONEIDA	NEW YORK	0.00555
330047	33380	MONTGOMERY	NEW YORK	0.00206
330053	33550	ORLEANS	NEW YORK	0.00042
330058	33530	ONTARIO	NEW YORK	0.00130
330074	33530	ONTARIO	NEW YORK	0.00099
330079	33270	FRANKLIN	NEW YORK	0.00113
330084	33270	FRANKLIN	NEW YORK	0.00085
330085	33570	OTSEGO	NEW YORK	0.00138
330090	33070	CHEMUNG	NEW YORK	0.00427
330096	33010	ALLEGANY	NEW YORK	0.00065
330103	33040	CATTARAUGUS	NEW YORK	0.00202
330108	33070	CHEMUNG	NEW YORK	0.00135
330115	33360	MADISON	NEW YORK	0.00075
330132	33040	CATTARAUGUS	NEW YORK	0.00061
330136	33570	OTSEGO	NEW YORK	0.00618
330140	33520	ONONDAGA	NEW YORK	0.01191
330144	33690	STEUBEN	NEW YORK	0.00035
330151	33690	STEUBEN	NEW YORK	0.00076
330153	33650	SCHENECTADY	NEW YORK	0.00605
330157	33330	JEFFERSON	NEW YORK	0.00253
330159	33520	ONONDAGA	NEW YORK	0.00287
330166	33060	CHAUTAUQUA	NEW YORK	0.00003

Provider Number	SSACD	County Name	State	Payment Weight Factor
330175	33210	CORTLAND	NEW YORK	0.00152
330177	33630	ST. LAWRENCE	NEW YORK	0.00028
330191	33750	WARREN	NEW YORK	0.00486
330197	33630	ST. LAWRENCE	NEW YORK	0.00118
330203	33520	ONONDAGA	NEW YORK	0.00746
330211	33630	ST. LAWRENCE	NEW YORK	0.00122
330213	33340	LEWIS	NEW YORK	0.00051
330215	33510	ONEIDA	NEW YORK	0.00151
330222	33640	SARATOGA	NEW YORK	0.00282
330223	33630	ST. LAWRENCE	NEW YORK	0.00087
330229	33060	CHAUTAUQUA	NEW YORK	0.00053
330235	33050	CAYUGA	NEW YORK	0.00213
330239	33060	CHAUTAUQUA	NEW YORK	0.00199
330241	33520	ONONDAGA	NEW YORK	0.00907
330245	33510	ONEIDA	NEW YORK	0.00552
330249	33360	MADISON	NEW YORK	0.00085
330263	33330	JEFFERSON	NEW YORK	0.00035
330265	33530	ONTARIO	NEW YORK	0.00073
330268	33660	SCHOHARIE	NEW YORK	0.00025
330276	33280	FULTON	NEW YORK	0.00108
330277	33690	STEUBEN	NEW YORK	0.00154
330307	33730	TOMPKINS	NEW YORK	0.00190
330394	33030	BROOME	NEW YORK	0.00715
330406	33650	SCHENECTADY	NEW YORK	0.00021
340011	34600	MITCHELL	NORTH CAROLINA	0.00086
340016	34490	JACKSON	NORTH CAROLINA	0.00148
340087	34550	MC DOWELL	NORTH CAROLINA	0.00071
340127	34380	GRANVILLE	NORTH CAROLINA	0.00081
340132	34900	VANCE	NORTH CAROLINA	0.00137
340159	34720	PERSON	NORTH CAROLINA	0.00073
340160	34190	CHEROKEE	NORTH CAROLINA	0.00122
350002	35070	BURLEIGH	NORTH DAKOTA	0.00432
350006	35500	WARD	NORTH DAKOTA	0.00373
350011	35080	CASS	NORTH DAKOTA	0.00874
350015	35070	BURLEIGH	NORTH DAKOTA	0.00365
350070	35080	CASS	NORTH DAKOTA	0.00297
360002	36020	ASHLAND	OHIO	0.00099
360148	36390	HOLMES	OHIO	0.00037
370018	37730	WASHINGTON	OKLAHOMA	0.00265
380001	38320	WASCO	OREGON	0.00075
380004	38330	WASHINGTON	OREGON	0.00661
380007	38250	MULTNOMAH	OREGON	0.00334
380009	38250	MULTNOMAH	OREGON	0.01203
380014	38010	BENTON	OREGON	0.00295

Provider Number	SSACD	County Name	State	Payment Weight Factor
380017	38250	MULTNOMAH	OREGON	0.00444
380021	38330	WASHINGTON	OREGON	0.00132
380025	38250	MULTNOMAH	OREGON	0.00110
380029	38230	MARION	OREGON	0.00040
380038	38020	CLACKAMAS	OREGON	0.00059
380040	38080	DESCHUTES	OREGON	0.00097
380047	38080	DESCHUTES	OREGON	0.00548
380050	38170	KLAMATH	OREGON	0.00229
380051	38230	MARION	OREGON	0.00558
380052	38220	MALHEUR	OREGON	0.00098
380056	38230	MARION	OREGON	0.00021
380060	38250	MULTNOMAH	OREGON	0.00204
380061	38250	MULTNOMAH	OREGON	0.00544
380082	38020	CLACKAMAS	OREGON	0.00060
380089	38020	CLACKAMAS	OREGON	0.00209
380091	38020	CLACKAMAS	OREGON	0.00010
390013	39720	UNION	PENNSYLVANIA	0.00189
390043	39710	TIOGA	PENNSYLVANIA	0.00082
390045	39510	LYCOMING	PENNSYLVANIA	0.00481
390061	39440	LANCASTER	PENNSYLVANIA	0.00141
390065	39000	ADAMS	PENNSYLVANIA	0.00155
390066	39460	LEBANON	PENNSYLVANIA	0.00348
390068	39440	LANCASTER	PENNSYLVANIA	0.00064
390071	39240	CLINTON	PENNSYLVANIA	0.00041
390079	39130	BRADFORD	PENNSYLVANIA	0.00665
390100	39440	LANCASTER	PENNSYLVANIA	0.01369
390225	39440	LANCASTER	PENNSYLVANIA	0.00233
390236	39130	BRADFORD	PENNSYLVANIA	0.00039
390268	39200	CENTRE	PENNSYLVANIA	0.00321
420071	42230	GREENWOOD	SOUTH CAROLINA	0.00605
430005	43140	CODINGTON	SOUTH DAKOTA	0.00143
430008	43050	BROOKINGS	SOUTH DAKOTA	0.00037
430012	43670	YANKTON	SOUTH DAKOTA	0.00166
430013	43170	DAVISON	SOUTH DAKOTA	0.00112
430014	43060	BROWN	SOUTH DAKOTA	0.00253
430015	43320	HUGHES	SOUTH DAKOTA	0.00069
430016	43490	MINNEHAHA	SOUTH DAKOTA	0.00724
430027	43490	MINNEHAHA	SOUTH DAKOTA	0.00965
430048	43400	LAWRENCE	SOUTH DAKOTA	0.00051
430077	43510	PENNINGTON	SOUTH DAKOTA	0.00749
430082	43510	PENNINGTON	SOUTH DAKOTA	0.00000
430089	43630	UNION	SOUTH DAKOTA	0.00050
430090	43490	MINNEHAHA	SOUTH DAKOTA	0.00043
430091	43510	PENNINGTON	SOUTH DAKOTA	0.00065

Provider Number	SSACD	County Name	State	Payment Weight Factor
430092	43060	BROWN	SOUTH DAKOTA	0.00023
430093	43510	PENNINGTON	SOUTH DAKOTA	0.00005
430094	43400	LAWRENCE	SOUTH DAKOTA	0.00003
430095	43410	LINCOLN	SOUTH DAKOTA	0.00290
430096	43670	YANKTON	SOUTH DAKOTA	0.00025
450154	45946	VAL VERDE	TEXAS	0.00088
450187	45952	WASHINGTON	TEXAS	0.00059
450604	45552	GILLESPIE	TEXAS	0.00169
460007	46100	IRON	UTAH	0.00062
460015	46020	CACHE	UTAH	0.00102
460017	46010	BOX ELDER	UTAH	0.00016
460019	46060	DUCHESNE	UTAH	0.00022
460026	46200	SEVIER	UTAH	0.00016
460030	46230	UINTAH	UTAH	0.00026
460033	46080	GARFIELD	UTAH	0.00006
460039	46010	BOX ELDER	UTAH	0.00006
460041	46050	DAVIS	UTAH	0.00099
460042	46050	DAVIS	UTAH	0.00107
460054	46020	CACHE	UTAH	0.00026
470001	47110	WASHINGTON	VERMONT	0.00153
470011	47120	WINDHAM	VERMONT	0.00085
490004	49421	HARRISONBURG CITY	VIRGINIA	0.00552
490005	49962	WINCHESTER CITY	VIRGINIA	0.01145
490013	49410	HALIFAX	VIRGINIA	0.00231
490018	49070	AUGUSTA	VIRGINIA	0.00456
490021	49551	LYNCHBURG CITY	VIRGINIA	0.01186
490024	49801	ROANOKE CITY	VIRGINIA	0.01659
490038	49860	SMYTH	VIRGINIA	0.00079
490041	49622	NEWPORT NEWS CITY	VIRGINIA	0.00295
490042	49600	MONTGOMERY COUNTY	VIRGINIA	0.00239
490048	49838	SALEM CITY	VIRGINIA	0.00608
490052	49622	NEWPORT NEWS CITY	VIRGINIA	0.00717
490053	49950	WASHINGTON	VIRGINIA	0.00216
490066	49961	WILLIAMSBURG CITY	VIRGINIA	0.00288
490075	49241	DANVILLE CITY	VIRGINIA	0.00367
490079	49561	MARTINSVILLE CITY	VIRGINIA	0.00263
490088	49088	BEDFORD CITY	VIRGINIA	0.00051
490089	49330	FRANKLIN	VIRGINIA	0.00068
490090	49730	PRINCE EDWARD	VIRGINIA	0.00126
490092	49328	FRANKLIN CITY	VIRGINIA	0.00089
490093	49411	HAMPTON CITY	VIRGINIA	0.00514
490098	49580	MECKLENBURG	VIRGINIA	0.00187
490105	49860	SMYTH	VIRGINIA	0.00001

Provider Number	SSACD	County Name	State	Payment Weight Factor
490109	49961	WILLIAMSBURG CITY	VIRGINIA	0.00004
490110	49600	MONTGOMERY	VIRGINIA	0.00216
490111	49980	WYTHE	VIRGINIA	0.00098
490115	49343	GALAX CITY	VIRGINIA	0.00133
490123	49510	LANCASTER	VIRGINIA	0.00082
490130	49360	GLOUCESTER	VIRGINIA	0.00128
490134	49670	NOTTOWAY	VIRGINIA	0.00001
490135	49800	ROANOKE	VIRGINIA	0.00010
490136	49200	CHESTERFIELD	VIRGINIA	0.00311
500002	50350	WALLA WALLA	WASHINGTON	0.00161
500012	50380	YAKIMA	WASHINGTON	0.00336
500016	50030	CHELAN	WASHINGTON	0.00491
500024	50330	THURSTON	WASHINGTON	0.00819
500036	50380	YAKIMA	WASHINGTON	0.00474
500037	50380	YAKIMA	WASHINGTON	0.00029
500049	50350	WALLA WALLA	WASHINGTON	0.00057
500050	50050	CLARK	WASHINGTON	0.00703
500072	50040	CLALLAM	WASHINGTON	0.00213
500139	50330	THURSTON	WASHINGTON	0.00172
500143	50330	THURSTON	WASHINGTON	0.00007
500148	50030	CHELAN	WASHINGTON	0.00022
500150	50050	CLARK	WASHINGTON	0.00269
510053	51480	UPSHUR	WEST VIRGINIA	0.00023
510072	51510	WETZEL	WEST VIRGINIA	0.00030
520002	52480	PORTAGE	WISCONSIN	0.00124
520004	52310	LA CROSSE	WISCONSIN	0.00269
520009	52430	OUTAGAMIE	WISCONSIN	0.00178
520011	52020	BARRON	WISCONSIN	0.00086
520013	52170	EAU CLAIRE	WISCONSIN	0.00395
520017	52080	CHIPPEWA	WISCONSIN	0.00060
520019	52420	ONEIDA	WISCONSIN	0.00120
520027	52440	OZAUKEE	WISCONSIN	0.00314
520028	52220	GREEN	WISCONSIN	0.00123
520030	52360	MARATHON	WISCONSIN	0.00522
520033	52700	WOOD	WISCONSIN	0.00080
520034	52350	MANITOWOC	WISCONSIN	0.00107
520035	52580	SHEBOYGAN	WISCONSIN	0.00167
520037	52700	WOOD	WISCONSIN	0.00753
520041	52100	COLUMBIA	WISCONSIN	0.00059
520044	52580	SHEBOYGAN	WISCONSIN	0.00110
520045	52690	WINNEBAGO	WISCONSIN	0.00209
520048	52690	WINNEBAGO	WISCONSIN	0.00166
520049	52040	BROWN	WISCONSIN	0.00298
520057	52550	SAUK	WISCONSIN	0.00063

Provider Number	SSACD	County Name	State	Payment Weight Factor
520066	52520	ROCK	WISCONSIN	0.00365
520070	52170	EAU CLAIRE	WISCONSIN	0.00411
520071	52270	JEFFERSON	WISCONSIN	0.00108
520075	52040	BROWN	WISCONSIN	0.00464
520076	52130	DODGE	WISCONSIN	0.00087
520087	52310	LA CROSSE	WISCONSIN	0.00471
520088	52190	FOND DU LAC	WISCONSIN	0.00188
520091	52420	ONEIDA	WISCONSIN	0.00105
520095	52550	SAUK	WISCONSIN	0.00073
520097	52040	BROWN	WISCONSIN	0.00174
520100	52520	ROCK	WISCONSIN	0.00198
520107	52350	MANITOWOC	WISCONSIN	0.00133
520109	52280	JUNEAU	WISCONSIN	0.00058
520113	52370	MARINETTE	WISCONSIN	0.00171
520116	52270	JEFFERSON	WISCONSIN	0.00120
520160	52430	OUTAGAMIE	WISCONSIN	0.00338
520193	52040	BROWN	WISCONSIN	0.00280
520196	52170	EAU CLAIRE	WISCONSIN	0.00016
520198	52690	WINNEBAGO	WISCONSIN	0.00129
520202	52360	MARATHON	WISCONSIN	0.00199
530006	53160	SHERIDAN	WYOMING	0.00100
530012	53120	NATRONA	WYOMING	0.00518
530033	53120	NATRONA	WYOMING	0.00038

Table 3: Section 1109 Payments by State for FY 2011

Name	Number of Counties with Eligible Hospitals	Number of Eligible Hospitals	Payments (in millions)	Percentage of payment
Alabama	4	4	$0.98	0.7%
Arizona	3	5	$1.64	1.1%
Arkansas	3	6	$3.01	2.0%
California	3	6	$2.16	1.4%
Colorado	3	3	$0.29	0.2%
Georgia	7	12	$6.65	4.4%
Hawaii	4	14	$5.63	3.8%
Idaho	8	14	$4.00	2.7%
Illinois	5	6	$1.73	1.2%
Indiana	10	12	$2.98	2.0%
Iowa	14	21	$12.43	8.3%
Kansas	3	4	$0.68	0.5%
Kentucky	2	2	$0.18	0.1%
Maine	4	5	$1.36	0.9%
Michigan	6	8	$1.68	1.1%
Minnesota	13	13	$3.98	2.7%
Mississippi	5	5	$1.28	0.9%
Missouri	8	13	$7.47	5.0%
Montana	7	10	$3.84	2.6%
Nebraska	4	4	$1.52	1.0%
New Mexico	13	24	$6.27	4.2%
New York	28	51	$17.24	11.5%
North Carolina	7	7	$1.08	0.7%
North Dakota	3	5	$3.51	2.3%
Ohio	2	2	$0.20	0.1%
Oklahoma	1	1	$0.40	0.3%
Oregon	9	21	$8.89	5.9%
Pennsylvania	9	13	$6.19	4.1%
South Carolina	1	1	$0.91	0.6%
South	11	19	$5.66	3.8%

Name	Number of Counties with Eligible Hospitals	Number of Eligible Hospitals	Payments (in millions)	Percentage of payment
Dakota				
Texas	3	3	$0.47	0.3%
Utah	8	11	$0.73	0.5%
Vermont	2	2	$0.36	0.2%
Virginia	27	31	$15.48	10.3%
Washington	6	13	$5.63	3.8%
West Virginia	2	2	$0.08	0.1%
Wisconsin	23	40	$12.44	8.3%
Wyoming	2	3	$0.98	0.7%
Total	273	416	$150,000,000.00	100.0%

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K. Rural Community Hospital Demonstration Program

We note that we included a discussion of continued implementation of the rural community hospital demonstration program in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24011). We issued a supplemental proposed rule (75 FR 30961) to the FY 2011 proposed rule (75 FR 23852) to address the provisions of the Affordable Care Act, which made changes to the demonstration program, and full implementation of the program for FY 2011. The discussion below reflects the provisions of both the proposed rule and the supplemental proposed rule.

1. Background

Section 410A(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), 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) of MMA, 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, in conjunction with subsections (2) and (3) of section 410A(a), provided 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).

We originally solicited applicants for the demonstration in May 2004; 13 hospitals began participation with cost reporting 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 were original participants 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.)

Section 410A(a)(5) of Public Law 108–173 originally required a 5-year demonstration period of participation. Prior to the enactment of the Affordable Care Act, for the seven currently participating hospitals that began the demonstration during FY 2005 ("originally participating hospitals"), 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.

In addition, section 410A(c)(2) of Public Law 108–173 required 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." This requirement is commonly referred to as "budget neutrality."

Generally, when we implement 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 the 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, respectively), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner.

In light of the statute's budget neutrality requirement, we proposed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24012) a methodology to calculate a budget neutrality adjustment factor to the FY 2011 national IPPS rates. In the FY 2011 IPPS/LTCH PPS proposed rule, the only amount that was identified to be offset for the FY 2011 IPPS/LTCH final rule was that 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 IPPS 2007 final rule as the budget neutrality offset for FY 2007. No dollar amount was specified for purpose of this offset, because of a delay in the settlement process of FY 2007 cost reports. Due to the timing of the proposed rule in relation to the enactment of the Affordable Care Act, we were unable to include in the proposed budget neutrality adjustment factor to the FY 2011 national IPPS rates an offset that would account for the estimated financial impact that the demonstration would have for certain timeframes under the extension required by the Affordable Care Act.

2. Changes to the Demonstration Program Made by the Affordable Care Act

Section 3123 of Public Law 111–148 and section 10313 of Public Law 111–152 amended section 410A of Public Law 108–173 which established the rural community hospital demonstration program. Sections 3123 and 10313 of the Affordable Care Act changed the rural community hospital demonstration program in several ways. First, the Secretary is required to conduct the demonstration program for an additional 5-year period that begins on the date immediately following the last day of the initial 5-year period under section 410A(a)(5) of Public Law 108–173, as amended (section 410A(g)(1) of Public Law 108–173, as added by section 3123(a) of the Affordable Care Act and further amended by section 10313 of such Act). Further, the Affordable Care Act requires that, in the case of a rural community hospital that is participating in the demonstration program as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural hospital in the demonstration program during the 5-year extension, unless the hospital makes an election, in such form and manner as the Secretary may specify, to discontinue participation (section 410A(g)(4)(A) of Public Law 108–173, as added by section 3123(a) of the Affordable Care Act and further amended by section 10313 of such Act). In addition, the Affordable Care Act provides that during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary to 20 (section 410A(g)(2) of Public Law 108–173, as added by section 3123(a) and amended by section 10313 of the Affordable Care Act). Further, the Secretary is required to use the same criteria and data that the Secretary used to determine the States under section 410A(a)(2) of Public Law 108–173 for purposes of the initial 5-year period. The Affordable Care Act also allows not more than 30 rural community hospitals in such States to participate in the demonstration during the 5-year extension period (section 410A(g)(3) of Public Law 108–173, as added by section 3123(a) of the Affordable Care Act and as further amended by section 10313 of such Act). Additionally, the Affordable Care Act provides that the amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than services furnished in a psychiatric or rehabilitation unit of the hospital that is a distinct part, is the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period (section 410A(g)(4)(b) of Public Law 108–173, as added by section 3123(a) of the Affordable Care Act and as further amended by section 10313 of such Act). For discharges occurring in a subsequent cost reporting period paid under the demonstration, the formula in section 410A(b)(1)(B) of Public Law 108–173, as amended, would apply. In addition, various other technical and conforming changes were made to section 410A of Public Law 108–173 by section 3123(a) of the Affordable Care Act and as further amended by section 10313 of such Act.

3. FY 2011 Budget Neutrality Adjustment

In order to ensure that the demonstration is budget neutral as is required by the statute, in the June 2, 2010 supplemental proposed rule, we proposed to adjust the national IPPS rates in the FY 2011 IPPS final rule to account for any added costs attributable to the demonstration. Specifically, the proposed budget neutrality adjustment would account for: (1) The estimated costs of the demonstration in FY 2011 for the 10 currently participating hospitals; (2) the estimated FY 2010 costs of the demonstration that were not accounted for in the FY 2010 IPPS/RY 2010 LTCH PPS final rule for the 7 "originally participating hospitals"

because we estimated those hospitals' FY 2010 costs under the assumption that the demonstration would be concluding before the end of FY 2010 for those hospitals; (3) the estimated FY 2011 costs for up to 20 new hospitals selected to participate in the demonstration; and (4) the amount by which the costs of the demonstration program, as indicated by settled cost reports for cost reporting periods beginning in FY 2007 for hospitals participating in the demonstration during FY 2007, exceeded the amount that was identified in the FY 2007 IPPS final rule as the budget neutrality offset for FY 2007.

a. Component of the FY 2011 Budget Neutrality Adjustment That Accounts for Estimated FY 2011 Costs of the Demonstration of the 10 Currently Participating Hospitals

In the June 2, 2010 supplemental proposed rule (75 FR 30962 and 30963), we indicated that the component of the proposed FY 2011 budget neutrality adjustment to the national IPPS rates that accounts for the estimated cost of the demonstration in FY 2011 for the 10 currently participating hospitals would be calculated by utilizing separate methodologies for the 7 hospitals that have participated in the demonstration since its inception and that we consider to be continuing to participate in the demonstration ("originally participating hospitals"), and the 3 hospitals that are currently participating in the demonstration that were among the 4 hospitals that joined the demonstration in 2008. Different methods are used because fiscal intermediaries' most recent final settlements of cost reports are for periods beginning in FY 2006 for the "originally participating hospitals," whereas we relied on available submitted documentation for the hospitals that began participation in the demonstration in 2008. Because the hospitals that began the demonstration in 2008 have no settled cost reports for the demonstration, we proposed to use "as submitted" cost reports. The proposed budget neutrality analysis was based on the assumption that all 10 of these hospitals would continue in the demonstration under the 5-year extension provided by the Affordable Care Act. We note that all 10 participating hospitals, whether they began participation in 2005 or in 2008, have elected to continue participation in the extension period mandated by the Affordable Care Act.

The estimate of the portion of the proposed budget neutrality adjustment that accounts for the estimated costs of the demonstration in FY 2011 for the 7 "originally participating hospitals" was based on data from their second year cost reports—that is, for cost reporting periods beginning in FY 2006. We proposed to use these cost reports because they were the most recent complete cost reports and, thus, we believed they enabled us to estimate FY 2011 costs as accurately as possible. In addition, we estimated the cost of the demonstration in FY 2011 for 2 of the 4 hospitals that joined the demonstration in 2008 based on data from each of their cost reporting periods beginning January 1, 2008. Similarly, we proposed to use these cost reports because they were the most recent cost reports and, thus, we believed they enabled us to estimate FY 2011 costs for these 2 hospitals as accurately as possible. Because 1 of the 4 hospitals that began in 2008 has withdrawn, there is 1 hospital remaining among those that began in that year. The remaining hospital of the 4 hospitals that began in 2008 is an Indian Health Service provider. Historically, the hospital has not filed standard Medicare cost reports. Therefore, in order to estimate its costs, we proposed to use an analysis of Medicare inpatient costs and payments submitted by the hospital for the cost reporting period of October 1, 2005 through September 30, 2006. In addition, we proposed that we may revise this estimate [that is, the estimated cost of the demonstration in FY 2011 for the 10 currently participating hospitals] for the final rule if updated cost report data became available. This is because we believe that updated data would enable us to estimate costs as accurately as possible.

For this final rule, we are finalizing an estimate of the costs of the demonstration in FY 2011 for the 10 currently participating hospitals. Consistent with our proposal, updated data have become available for this final rule, and we are using them to estimate the costs of the demonstration in FY 2011. The finalized amount differs from that stated in the proposed rule in two respects: (1) A more recently available IPPS market basket update factor for FY 2011 is applied to the difference between the dollar amount attributable to Medicare inpatient costs calculated under the applicable reasonable cost methodology in section 410A of Public Law 108–173, as amended, and what would have otherwise been paid under the IPPS. (An IPPS market basket update is applied for every year between the year of the respective cost report and 2011.) (2) The updated cost report data have become available for the Indian Health Service provider because the provider has filed a full cost report for its cost reporting period ending September 30, 2009.

For this final rule, the estimated costs under the demonstration for FY 2011 for the 10 currently participating hospitals is calculated as follows: Consistent with the proposed rule, in order to estimate the FY 2011 costs of the demonstration for the seven "originally participating hospitals," for each hospital we subtracted the amount it would have been paid under the IPPS from the amount paid for FY 2006 under the applicable reasonable cost methodology in section 410A of Public Law 108–173 as amended. We summed these differences for the seven hospitals and applied the IPPS market basket updates and a 2-percent annual volume adjustment for the years between 2006 and 2011. As proposed, for this final rule for the two hospitals that began the demonstration in 2008, for each of these hospitals we subtracted the amount it would have been paid under the IPPS from the amount to be paid under the applicable reasonable cost methodology in section 410A of Public Law 108–173 as amended for FY 2008 using as submitted 2008 cost reports. We summed these differences and applied the IPPS market basket updates and a 2-percent annual volume adjustment for the years between 2008 and 2011. For the Indian Health Service provider, we used its as submitted cost report ending in September 2009 to estimate its FY 2011 costs under the applicable reasonable cost methodology set forth in section 410A of Public Law 108–173 as amended and what its Medicare inpatient payment would have been absent the demonstration. We added the amounts for all 10 hospitals, resulting in an estimated amount of $21,331,721.

b. Portion of the FY 2011 Budget Neutrality Adjustment That Accounts for Estimated FY 2010 Costs of the Demonstration That Were Not Accounted for in the FY 2010 IPPS/RY 2010 LTCH PPS Final Rule for the Seven "Originally Participating Hospitals"

As explained above, section 410A(g)(4)(A) of Public Law 108–173, as added by section 3123(a) of the Affordable Care Act and further amended by section 10313 of such Act, provided for the continued participation of rural community hospitals that were participating in the demonstration as of the last day of the initial 5-year [demonstration] period. One of the effects of this extension is that the seven "originally participating hospitals" (those hospitals that have participated in the demonstration since its inception

and that continue to participate in the demonstration or were participating in the demonstration as of the last day of their initial 5-year demonstration period, that is, the two rural community hospitals that concluded their initial period of performance in December 2009) that were scheduled to end their participation in the demonstration before the end of FY 2010 would continue to participate for the remainder of FY 2010 and beyond, as applicable. However, we note that the portion of the FY 2010 budget neutrality adjustment to the national IPPS rates that was included in the FY 2010 IPPS final rule that accounted for the estimated costs of the demonstration in FY 2010 did not take into account costs of the demonstration for those hospitals beyond the anticipated end date of their initial demonstration period. (For example, for a hospital whose cost report ended in June 30, 2010, we counted only 9 months for the budget neutrality adjustment for the FY 2010 IPPS/LTCH PPS final rule. Under our proposal, we would adjust the national IPPS rates to account for the estimated costs for this hospital for the remaining 3 months of FY 2010.) Therefore, as proposed, in this final rule, we are including a component in the FY 2011 budget neutrality adjustment to account for the estimated costs of the demonstration in FY 2010 that were not accounted for in the FY 2010 IPPS/RY 2010 LTCH PPS final rule for the seven "originally participating hospitals" because we calculated the FY 2010 cost estimate for that year's final rule assuming that the demonstration would end before the end of that fiscal year for those hospitals. As we proposed, we are using the following methodology to account for such estimated costs:

- Step One. For each of the seven "originally participating hospitals," we divide the number of months that were not included in the estimate of the FY 2010 demonstration costs included in the FY 2010 IPPS/RY 2010 LTCH PPS final rule by 12. This step is necessary to determine for each of the seven "originally participating hospitals" the fraction of FY 2010 for which the estimate of the FY 2010 demonstration was not included.
- Step Two. For each of the seven "originally participating hospitals," the percentage that results in step one is multiplied by the estimate of the cost attributable to the demonstration in FY 2010 for the hospital. The estimate for the fraction of the hospital's cost for FY 2010 not included in the estimate in the FY 2010 IPPS/RY 2010 LTCH PPS final rule is arrived at by multiplying this fraction by the estimate of costs for the entire year.

The estimate of the costs of the demonstration for FY 2010 for the seven "originally participating" hospitals is derived from data found in their cost reports for cost reporting years beginning in FY 2006. These cost reports show dollar amounts for costs for Medicare inpatient services (that is, the Medicare payment amount in that cost reporting year for Medicare inpatient services that results from application of the applicable methodology set forth in section 410A of Pub. L. 108–173) and the dollar amount that would have been paid under the IPPS. Because these cost reporting years all ended during FY 2007, this difference (that is, the difference between the Medicare payment amount in that cost reporting year for Medicare inpatient services that is calculated under the methodology set forth in section 410A of Pub. L. 108–173 and the dollar amount that would have been paid under the IPPS), respective to each of the seven "originally participating hospitals," is updated according to the market basket updates for inpatient hospital costs reported by the CMS Office of the Actuary for the years from FY 2008 through FY 2011. (We also have assumed an annual 2 percent volume increase in accordance with guidance from the CMS Office of the Actuary.) The difference for each hospital is summed to arrive at the estimate of additional costs attributable to the demonstration in FY 2010 for such hospitals. (This calculation is not necessary for the hospitals that began participating in the demonstration in 2008 because the portion of the FY 2010 budget neutrality adjustment that accounts for estimated FY 2010 demonstration costs in the FY 2010 IPPS/RY 2010 LTCH PPS final rule incorporates a cost estimate for each of these hospitals based on the entirety of the Federal fiscal year.) The estimate of additional costs attributable to the demonstration in FY 2010 for the seven "originally participating hospitals" that were not accounted for in the FY 2010 final rule is $6,488,221.

c. Portion of the FY 2011 Budget Neutrality Adjustment That Accounts for Estimated FY 2011 Costs for Hospitals Newly Selected To Participate in the Demonstration

Section 410A(g)(3) of Public Law 108–173, as added by section 3123 of the Affordable Care Act and as further amended by section 10313 of such Act, provides that "[n]otwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section." Consequently, up to 20 additional hospitals may be added to the demonstration (30 hospitals minus the 10 currently participating hospitals). In order to ensure budget neutrality for 20 new participating hospitals, as we proposed in the June 2, 2010 supplemental proposed rule, we are including a component in the budget neutrality adjustment factor to the FY 2011 national IPPS rates to account for the estimated FY 2011 costs of those new hospitals. As proposed, for this final rule, for purposes of estimating the FY 2011 costs of the demonstration for 20 new hospitals, we are estimating such costs from the average annual cost per hospital derived from the estimate of the 10 currently participating hospitals' costs attributable to the demonstration for FY 2011. Because the statute allows the potential for 20 additional hospitals for the demonstration, we are basing this estimate on the assumption that 20 hospitals will join. Our experience analyzing the cost reports so far for demonstration hospitals shows a wide variation in costs among the hospitals. Given the wide variation in cost profiles that might occur for additional hospitals, we believe that estimating the total demonstration cost for FY 2011 for 20 additional hospitals from the average annual cost of the currently existing hospitals yields the most accurate prediction because it is reflective of the historical trend of participant behavior under the demonstration and should give an accurate as possible prediction of future participant behavior. We believe that, although there is variation in costs, formulating an estimate from the average costs of as many as 10 hospitals gives as good as possible a prediction of what the demonstration costs for each of 20 additional hospitals would be. We are estimating the average cost for each of the 20 additional hospitals, not a range of costs. According to the estimate of this average cost per hospital, obtained by dividing $21,331,721, the cost amount for FY 2011 identified for the 10 participating hospitals in IV.F.3.a. of this preamble, by 10 and then multiplying by 20, the estimate for costs attributable to the demonstration for 20 additional hospitals in FY 2011 is $42,663,442. (In the proposed rule, we neglected to state that the estimated costs attributable to the demonstration for 20 additional hospitals in FY 2011 was the average cost attributable to the demonstration per hospital for FY 2011 times 20,

although the estimated costs for such hospitals reflected this calculation).

d. Portion of the FY 2011 Budget Neutrality Adjustment To Offset the Amount by Which the Costs of the Demonstration in FY 2007 Exceeded the Amount That Was Identified in the FY 2007 IPPS Final Rule as the Budget Neutrality Offset for FY 2007

In addition, in order to ensure that the demonstration in FY 2007 was budget neutral, in the June 2, 2010 supplemental proposed rule (75 FR 30964), we proposed to incorporate a component into the budget neutrality adjustment factor to the FY 2011 national IPPS rates, which 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 IPPS final rule as the budget neutrality offset for FY 2007. Specifically, we proposed the following methodology:

- Step One: 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 of the demonstration for each of the then participating hospitals). (We proposed to use these settled cost reports, which represent the third year of the demonstration for each of the then participating hospitals, because they correspond most precisely to FY 2007 and, therefore, we believe correctly represent FY 2007 inpatient costs for the demonstration during that period.)
- Step Two: 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 one.
- Step Three: The result of step two is a dollar amount, for which we would calculate a factor that would offset such amounts and would be incorporated into the overall budget neutrality adjustment to national IPPS rates for FY 2011. This specific component to the overall budget neutrality adjustment for FY 2011 would account for the difference between the costs of the demonstration in FY 2007 and the amount of the budget neutrality adjustment published in the FY 2007 IPPS final rule and, therefore, would ensure that the demonstration is budget neutral for FY 2007.

Because the settlement process for the demonstration hospitals' third year cost reports, that is, for cost reporting periods starting in FY 2007, had experienced a delay, for the FY 2011 IPPS/LTCH PPS proposed rule and the supplemental propose rule, we were unable to state the costs of the demonstration corresponding to FY 2007 and as a result were unable to propose the specific numeric adjustment representing this offsetting process that would be applied to the national IPPS rates. Due to operational issues in the cost report settlement process, settled cost reports for the hospitals that participate in the demonstration in FY 2007 are not available in time for this final rule either, although we expected them to be available. Therefore, the estimated adjustment to the national IPPS rates in this final rule cannot include a component to account for these costs. We anticipate that this information may be available for the FY 2012 IPPS/LTCH PPS proposed rule, at which time we would include a similar proposal.

For this final FY 2011 IPPS/LTCH PPS final rule, the estimated amount for the adjustment to the national IPPS rates is the sum of the amounts specified in sections V.K.3.a. through c. of this final rule, which is $70,483,384. Section V.K.3.a. through c. of this final rule state dollar amounts, which represent estimated costs attributable to the demonstration for the respective component of the overall estimated calculation of the budget neutrality factor for FY 2011. This estimated amount is based on the specific assumptions identified, as well as from data sources that are used because they represent either the most recently finalized or, if as submitted, recent available cost reports.

We did not receive any public comments on the proposed provisions for extension of the rural hospital community demonstration program.

L. 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. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23998), we proposed to make this conforming change. We did not receive any public comments on our proposal. Therefore, we are adopting the proposed conforming change as final without modification.

M. Interim Final Rule With Comment Period: Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window

1. Introduction

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111–192) was enacted. Section 102 of Public Law 111–192 pertains to Medicare's policy for payment of outpatient services provided on either the day of or during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) prior to a Medicare beneficiary's inpatient admission. This policy is generally known as the "3-day payment window". Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a Medicare beneficiary's inpatient stay, the charges for all outpatient diagnostic services and admission-related nondiagnostic services provided during the payment window. The new law makes the policy pertaining to admission-related nondiagnostic services more consistent with common hospital billing practices. Section 102 is effective for services furnished on or after the date of enactment, June 25, 2010.

2. Background for Policy

Section 1886(a)(4) of the Act originally defined the operating costs of inpatient hospital services to include "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis." On November 5, 1990, the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) was enacted. Section 4003(a) of Public Law 101–508 amended the statutory definition of "operating costs of inpatient hospital services" to include the costs of certain services furnished prior to admission. These preadmission services are to be included on the Medicare Part A bill for the subsequent inpatient stay. As amended, section 1886(a)(4) of the Act defines the operating costs of inpatient hospital services to include diagnostic services

(including clinical diagnostic laboratory tests) or other services related to the admission (as defined by the Secretary) furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) to the patient during the 3 days prior to the date of the patient's admission to the hospital. The provisions of section 4003(b) of Public Law 101–508 were fully implemented by October 1, 1991.

On January 12, 1994, we published an interim final rule with comment period (59 FR 1654) regarding section 4003 of Public Law 101–508. In that final rule with comment period, we revised the regulations at 42 CFR 412.2 relating to hospitals paid under the IPPS (also referred to as "subsection (d) hospitals") and 42 CFR 413.40(c) relating to hospitals excluded from the IPPS (also referred to as "non-subsection (d) hospitals"). Specifically, we added § 412.2 (c)(5) and revised § 413.40(c) to provide that a hospital is considered the sole operator of an entity if the hospital has exclusive responsibility for conducting or overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. In addition, we stated that ambulance services are excluded from preadmission services subject to the payment window and defined "services related to the admission" as those nondiagnostic services that are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient.

Section 1886(a)(4) of the Act was further amended by section 110 of the Social Security Amendments of 1994 (Pub. L. 103–432, enacted on October 31, 1994). That provision revised the payment window for hospitals that are excluded from the IPPS to include only those services furnished by the hospital or an entity wholly owned or operated by the hospital during the 1 day (not 3 days) prior to a patient's hospital inpatient admission. In a September 1, 1995 final rule (60 FR 45840), we revised § 413.40(c)(2) of the regulations to provide for the 1-day payment window for hospitals and hospital units excluded from the IPPS. The hospitals and hospital units excluded from the IPPS and affected by this policy are psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals (LTCHs), children's hospitals, and cancer hospitals. CMS also noted that the term "day" refers to the entire calendar day immediately preceding the date of admission, not the 24-hour time period that immediately precedes the hour of admission.

On February 11, 1998, we published a final rule (63 FR 6864) that responded to public comments received on the January 12, 1994 interim final rule with comment period. In that final rule, CMS stated again that ambulance services are excluded from the payment window provision and also stated that chronic maintenance renal dialysis are excluded, as reflected in §§ 412.2(c)(5)(iii) and §§ 413.40(c)(2)(iii) of the regulations. We also clarified in that final rule that the payment window applies to outpatient services that are otherwise billable under Part B and does not apply to nonhospital services that are generally covered under Part A (such as home health, skilled nursing facility, and hospice). In addition, we further clarified the terms "admission-related" and "wholly owned or operated."

In an April 2006 update to the Medicare Claims Processing Manual (Pub. 100–4), Chapter 3, section 40.3 (Change Request 4089, Transmittal 714), we revised the manual instructions to clarify that the 3-day (or 1-day) payment window policy also applies to outpatient services provided on the date of a beneficiary's admission, consistent with Medicare's longstanding administrative policy for treating preadmission outpatient services as inpatient. We also clarified that critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) payment window.

3. Requirements of Section 102 of Public Law 111–192

Section 102(a)(1) of Public Law 111–192 added a provision to section 1886(a)(4) of the Act to specify that the term "other services related to the admission" includes "all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title [Title XVIII] that are provided by a hospital (or an entity wholly owned or wholly operated by the hospital) to a patient—(A) on the date of the patient's inpatient admission; or (B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission."

Section 102(b) specifies that the amendments made by section 102(a) of the law apply "to services furnished on or after the date of the enactment" (that is, June 25, 2010).

The law makes no changes to the billing of "diagnostic services" furnished during this period, which are included in the "operating costs of inpatient hospital services" pursuant to section 1886(a)(4) of the Act (which we discuss in our regulations and in section 40.3(B), Chapter 3, of the Medicare Claims Processing Manual). All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or operated by the hospital) on the date of the beneficiary's inpatient admission and during the 3 calendar days (1 calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

Section 102(c) of Public Law 111–192 also prohibits Medicare from reopening a claim, adjusting a claim, or making payments pursuant to any request for payment under Title 18, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital), for services (as described in section 102(c)(2) of Pub. L. 111–192), for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission. Services described in section 102(c)(2) of Public Law 111–192 are other services related to the admission which were previously included on a claim or request for payment submitted under part A of Title XVIII for which a reopening, adjustment, or request for payment under part B of Title XVIII, was not submitted prior to June 25, 2010 for purposes of treating, as unrelated to a patient's inpatient admission.

4. Application of the Provisions of Section 102 of Public Law 111–192

In accordance with section 1886(a)(4) of the Act, outpatient nondiagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission. In accordance with section 102 of Public Law 111–192, for outpatient services furnished on or after June 25, 2010, all nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a

beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay. In addition, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for nonsubsection (d) hospitals) preceding the date of a beneficiary's admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the hospital attests to certain nondiagnostic services as unrelated to the hospital claim (that is, the preadmission services are clinically distinct or independent from the reason for the beneficiary's admission). Outpatient nondiagnostic services provided during the applicable payment window that are unrelated to the admission, and are covered by Medicare Part B, should be separately billed to Medicare Part B.

We intend to establish a process for hospitals to attest to nondiagnostic services as being unrelated to the hospital claim when a hospital submits an outpatient claim. As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim that the outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission. We note that hospitals have experience with making similar attestations on the outpatient or inpatient claim. For example, under Medicare's current policy, when a patient is discharged or transferred from an acute care prospective payment system (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to the prior stay, the second stay is bundled into payment for the first stay and not separately paid. However, when a patient is discharged or transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to the prior stay, hospitals can place condition code (CC) B4 on the inpatient claim that contains an admission date equal to the prior admissions discharge date that would allow the second stay to be paid separately. If the condition code is not included on the claim for a same day readmission, edits will bundle the claim for the second admission into the first one and Medicare will only pay for one inpatient discharge. (We refer readers to section 40.2.5, Chapter 3 of the Medicare Claims Processing Manual and the FY 2003 IPPS final rule (68 FR 45404–06) for further details of Medicare's policy on this issue.) We plan to develop a similar process using a condition code, modifier, or some other indicator for the 3-day (1-day) payment window.

In accordance with the requirements of section 1886(a)(4) of the Act, as amended by section 102(a) of Public Law 111–192, we are modifying the Medicare regulations at § 412.2 by revising paragraph (c)(5) and adding a new paragraph (c)(5)(iv) to specify that all nondiagnostic services provided on or after June 25, 2010, other than ambulance and maintenance renal dialysis services, provided by a subsection (d) hospital (or by an entity wholly owned or operated by the subsection (d) hospital) on the date of a beneficiary's inpatient admission are deemed related to and, therefore, part of the beneficiary's inpatient stay. In addition, outpatient nondiagnostic services provided on the first, second, and third calendar day prior to admission by a subsection (d) hospital are also deemed related to and, therefore, part of the beneficiary's inpatient stay, unless a hospital attests that specific nondiagnostic services are clinically unrelated to the inpatient admission (that is, the preadmission services are distinct or independent from the admission) when the hospital submits an outpatient claim.

For nonsubsection (d) hospitals, in accordance with section 1886(a)(4) of the Act, the payment window is 1 day. Therefore, in this interim final rule with comment period, we are amending § 413.40 by revising paragraph (c)(2) and (c)(2)(iii) and adding a new paragraph (c)(2)(iv) to provide that all nondiagnostic services provided on or after June 25, 2010 (other than ambulance and maintenance renal dialysis services) that are provided on the date of a beneficiary's admission by a nonsubsection (d) hospital (or by an entity wholly owned or operated by the nonsubsection (d) hospital) are deemed related to and, thus, part of the beneficiary's inpatient stay at that nonsubsection (d) hospital. In addition, nondiagnostic services provided by a nonsubsection (d) hospital (or by an entity wholly owned or operated by the nonsubsection (d) hospital) during the 1 calendar day immediately preceding the date of admission to that nonsubsection (d) hospital are deemed related to and, thus, part of the inpatient stay, unless the hospital attests that specific nondiagnostic services are clinically unrelated to the inpatient admission when the hospital submits an outpatient claim.

In this interim final rule with comment period, we also are codifying the same statutory requirements of the payment window for IPFs, LTCHs, and IRFs by adding a new § 412.405 applicable to payments to IPFs for treating preadmission services as inpatient operating costs under the IPF prospective payment system, a new § 412.540 applicable to payments to LTCHs for treating preadmission services as inpatient operating costs under the LTCH prospective payment system, and a new paragraph (f) (existing paragraph (f) is redesignated as paragraph (g)) to § 412.604 to be applicable to payments to IRFs for treating preadmission services as inpatient operating costs under the IRF PPS.

In addition, we are making a technical correction to our existing regulation at § 412.521(b)(1), which sets forth our policy under the LTCH PPS for what constitutes payment in full to providers for covered operating costs for inpatient services. This is a conforming change that is necessary to recognize the addition of § 412.540 described previously. Consequently, we are amending the cross-reference at § 412.521(b) to read instead "§ 412.2(c)(1) through (c)(4) of this Part and § 412.540." This correction results in an accurate description of the policy under the LTCH PPS for determining Medicare payment in full for inpatient operating costs.

Section 102(c) of Public Law 111–192 also prohibits Medicare from reopening a claim, adjusting a claim, or making payments pursuant to any request for payment under Title XVIII, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital), for services (as described under section 102(c)(2) of Pub. L. 111–192) for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission. Services described in section 102(c)(2) of Public Law 111–192 are other services related to the admission which were previously included on a claim or request for payment submitted under Part A of Title XVIII for which a reopening, adjustment, or request for payment under Part B of Title XVIII, was not submitted prior to June 25, 2010 for purposes of treating, as unrelated to a patient's inpatient admission.

For example, if a beneficiary presented with chest pain at the emergency department of a subsection (d) hospital on June 1, 2010, was

retained for observation until admitted as an inpatient on June 3, 2010 (with a principal diagnosis of myocardial infarction), was released from the hospital on June 7, 2010, and the hospital billed Medicare Part A on June 10, 2010, for the beneficiary's entire stay (bundling all of the outpatient charges and procedures on the inpatient stay bill), Medicare will make no payment to the hospital for any Part A adjustment claims submitted on or after June 25, 2010, to remove unrelated outpatient nondiagnostic services, nor for any new Part B claims submitted on or after June 25, 2010, to separately bill Medicare for unrelated outpatient nondiagnostic services, that the hospital had previously included on its June 10, 2010 bill for services furnished to the beneficiary.

In the near future, we also expect to update the instructions in the Medicare Claims Processing Manual, Chapter 3, section 40.3, to conform to the requirements of section 102 of Public Law 111–192. Even before the final regulations, instructions, and process for attesting to certain services as being unrelated to an admission are in place, hospitals are required by law to comply with the requirements of section 102 of Public Law 111–192. That is, hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all outpatient preadmission diagnostic services and all outpatient preadmission nondiagnostic services that meet the requirements of section 1886(a)(4) of the Act, as amended by section 102 of Public Law 111–192. If a hospital believes that outpatient nondiagnostic services provided during the first, second, and third calendar days (first calendar day for a nonsubsection (d) hospital) preceding the date of a beneficiary's admission are unrelated to the inpatient admission, the hospital may separately bill for the service to Medicare Part B, provided that the hospital can document, and maintain such documentation as part of the beneficiary's medical record to support its belief, that the service is unrelated to the admission. Such separately billed outpatient preadmission services may be subject to subsequent CMS review.

5. Waiver of Notice of Proposed Rulemaking

In section IV.M. of this document, we are implementing section 102 of Pub. L. 111–192, which addresses Medicare payment for outpatient services provided prior to a Medicare beneficiary's inpatient admission, through an interim final rule with comment period. We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide for public comment before the provisions of a rule take effect, in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. This process may be waived, however, if an agency finds good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest. In such cases, the agency must incorporate a statement of this finding and its reasons in the rule, or explain that the agency is promulgating interpretive rules, general statements of policy, or rules of agency procedure or practice outside the scope of notice and comment rulemaking.

We believe that there is good cause to implement the requirements of section 102 of Public Law 111–192 through an interim final rule with comment period. Notice and comment rulemaking would be unnecessary and contrary to the public interest in this case. The provisions of section 102 are self-implementing; we are conforming our regulations to specific statutory requirements contained in that section or that directly result from those statutory requirements and informing the public of the procedures and practices the agency will follow to ensure compliance with those statutory provisions. Moreover, section 102 of Public Law 111–192 was effective on June 25, 2010, and it is imperative that the regulatory provisions be set forth as soon as possible to deliver the guidance necessary for providers to comply with requirements that are already in place.

In addition, the requirements of section 102 of Public Law 111–192 may be implemented as an interim final rule with comment period because they fall under the exception to notice and comment rulemaking contained in section 1871(b)(1)(B) of the Act. Section 1871(b)(1)(B) of the Act provides that the Secretary is not required to issue a notice of proposed rulemaking before issuing a final rule if "a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained." Section 102 of Public Law 111–192 was effective on the date of enactment, thereby meeting this requirement.

Section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act ordinarily require that a regulation be effective no earlier than 30 days after publication. Under section 553(d)(3), this requirement can be waived for good cause, and under section 1871(e)(1)(B)(ii) of the Act, this requirement can be waived if necessary to comply with statutory requirements, or if a delay is contrary to the public interest. As noted above, section 102 of Public Law 111–192 is required by statute to be in effect on the date of enactment. For the reasons identified above for waiving notice and comment procedures under the APA and the Act, we find good cause to waive the 30-day delay in effective date that would otherwise apply.

In addition, 5 U.S.C. 801 generally requires that agencies submit major rules to the Congress 60 days before the rules are scheduled to become effective. This delay does not apply, however, when there has been a finding of good cause for waiver of prior notice and comment as set forth above.

6. Collection of Information Requirements

This document does not impose any new information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

7. Response to Public 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 public 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 of that document.

8. Regulatory Impact Analysis

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 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).

As discussed earlier in this interim final rule with comment period, section 1886(a)(4) of the Act defines the operating costs of inpatient hospital services to include diagnostic services (including clinical diagnostic laboratory tests) or other services related to the admission (as defined by the Secretary) furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) prior to the date of the patient's admission to the hospital. This policy is generally known as the "3-day payment window." Section 102(a)(1) of Public Law 111–192, enacted June 25, 2010, added a provision to section 1886(a)(4) of the Act to specify that the term "other services related to the admission" includes "all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title [Title XVIII] that are provided by a hospital (or an entity wholly owned or wholly operated by the hospital) to a patient (A) on the date of the patient's inpatient admission; or (B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission." Section 102(b) specifies that the amendments made by section 102(a) of Public Law 111–192 apply "to services furnished on or after the date of the enactment" (that is, June 25, 2010).

The law makes no changes to the existing policy regarding billing of "diagnostic services" furnished during this period, which are included in the "operating costs of inpatient hospital services" pursuant to section 1886(a)(4) (which we discuss in our regulations and in section 40.3(B), Chapter 3, of the MCPM). All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or operated by the hospital) on the date of the beneficiary's inpatient admission and during the 3 calendar days (1 calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

Section 102(c) of Public Law 111–192 also prohibits Medicare from reopening a claim, adjusting a claim, or making payments pursuant to any request for payment under Title 18, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital), for services (as described in section 102(c)(2) of Public Law 111–192), for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission. Services described in section 102(c)(2) of Public Law 111–192 are other services related to the admission which were previously included on a claim or request for payment submitted under part A of Title 18 for which a reopening, adjustment, or request for payment under part B of Title 18, was not submitted prior to June 25, 2010 for purposes of treating the services as unrelated to a patient's inpatient admission.

We note that, in a final rule published on February 11, 1998 (63 FR 6864), we had defined "other services" as being "related to the admission" only when there was an exact match (for all 5 digits, if applicable) between the principal (or primary) ICD–9–CM diagnosis codes assigned for both the preadmission services (provided by the admitting hospital or by an entity that is wholly owned or operated by the admitting hospital) and the inpatient stay. If hospitals, prior to the June 25, 2010 effective date of section 102 of Public Law 111–192, were applying the definition of "related" as adopted in that final rule, we estimate that the impact of the provisions of section 102 of Public Law 111–192, for FY 2011, would be a savings of approximately $2.6 billion to Medicare Part B, and the impact on Medicare Part A would be negligible. In addition, we estimate that the impact on beneficiaries would be a savings of about $0.5 billion for FY 2011. However, we were informed by many hospitals, Medicare contractors, and others in the hospital community that the policy established in 1998 was generally unknown to hospitals and that the policy being enacted under section 102(a) is more consistent with hospitals' longstanding billing practices. The hospitals and others asserted that, for the most part, hospitals have been treating virtually all outpatient services furnished to a patient during the payment window as admission-related and bundling the services onto the Part A claim for the patient's inpatient stay, particularly when a patient is admitted as an inpatient directly from an outpatient department of the hospital, such as the emergency department. If this assertion is correct, then the impact of the provisions of section 102 of Public Law 111–192 for FY 2011 on the Medicare program and its beneficiaries would be negligible.

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 604 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 LTCH PPS, we continue to classify these hospitals as urban hospitals. We believe that this rule will not have a significant impact on small rural hospitals. Accordingly, the Secretary certifies that this interim final rule with comment period would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (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 interim final rule with comment period 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. Because this interim final rule with comment period does not impose any costs on State or local government, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

N. Changes in the Inpatient Hospital Market Basket Update

Below we discuss the adjustments to the FY 2010 and FY 2011 market basket as required by the Affordable Care Act and our incorporation of the statutory provisions in the Medicare regulations. In this final rule, we are not addressing the provisions of section 3401 of the Affordable Care Act that provide for a productivity adjustment for FY 2012 and subsequent fiscal years. This statutory change will be addressed in future rulemaking.

1. FY 2010 Inpatient Hospital Update

In accordance with section 1886(b)(3)(B)(i) of the Act, each year we update the national standardized amount for inpatient operating costs by a factor called the "applicable percentage increase." Prior to enactment of the Affordable Care Act, section 1886(b)(3)(B)(i)(XX) of the Act set the applicable percentage increase equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality data 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 quality data, the update is equal to the market basket percentage increase less an additional 2.0 percentage points. In accordance with these statutory provisions, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43850), we finalized an applicable percentage increase equal to the full market basket update of 2.1 percent based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2010 market basket increase, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we finalized an applicable percentage increase equal to 0.1 percent (that is, the FY 2010 estimate of the market basket rate-of-increase minus 2.0 percentage points).

Sections 3401(a) and 10319 of the Affordable Care Act amended section 1886(b)(3)(B)(i) of the Act. As amended, section 1886(b)(3)(B)(i) sets the FY 2010 applicable percentage increase for IPPS hospitals equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas minus a 0.25 percentage point, subject to the hospital submitting quality data 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 minus 0.25 percentage point less an additional 2.0 percentage points. Section 3401(a)(4) of the Affordable Care Act further states that these amendments may result in the applicable percentage increase being less than zero. Although these amendments modify the applicable percentage increase applicable to the FY 2010 rates under the IPPS, section 3401(p) of the Affordable Care Act states that the amendments do not apply to discharges occurring prior to April 1, 2010. In other words, for discharges occurring on or after October 1, 2009 and prior to April 1, 2010, the rate for a hospital's inpatient operating costs under the IPPS will be based on the applicable percentage increase set forth in the FY 2010 IPPS/RY 2010 LTCH PPS final rule.

In the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30922), we proposed to revise the regulations at 42 CFR 412.64(d) to reflect current law. Specifically, in accordance with section 1886(b)(3)(B)(i) of the Act as amended by sections 3401(a) and 10319(a) of the Affordable Care Act, we proposed to revise § 412.64(d) to state that, for the first half of FY 2010 (that is, discharges on or after October 1, 2009 through March 30, 2010), the applicable percentage change equals the market basket index for IPPS hospitals (which is defined under § 413.40(a)) in all areas for hospitals that submit quality data in accordance with our rules, and the market basket index for IPPS hospitals in all areas less 2.0 percentage points for hospitals that fail to submit quality data in accordance with our rules. As noted above, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we calculated that the full market basket update equals 2.1 percent based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2010 market basket increase. In addition, in the supplemental proposed rule, we proposed to revise § 412.64(d) to state that, for the second half of FY 2010 (discharges on or after April 1, 2010 through September 30, 2010), in accordance with section 3401(a) of the Affordable Care Act, the applicable percentage change equal to the market basket index for IPPS hospitals in all areas reduced by 0.25 percentage points for hospitals that submit quality data in accordance with our rules. For those hospitals that fail to submit quality data, in accordance with our rules, we proposed to specify that the market basket index for IPPS hospitals is reduced by an additional 2.0 percentage points (which is in addition to the 0.25 percentage point reduction required by section 1886(b)(3)(B)(i) of the Act as amended by section 3401(a) of the Affordable Care Act and as further amended by section 10319(a) of that Act). Based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2010 market basket increase, the FY 2010 applicable percentage change that applies to rates for inpatient hospital operating costs under the IPPS for discharges occurring in the second half of FY 2010 is 1.85 percent (that is, the FY 2010 estimate of the market basket rate-of-increase of 2.1 percent minus 0.25 percentage points) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the payment update to the operating standardized amount is −0.15 percent (that is, the adjusted FY 2010 estimate of the market basket rate-of-increase of 1.85 percent minus 2.0 percentage points). We received one public comment which we respond to below on our proposal to revise § 412.64(d) to reflect current law. However, due to the statutory requirement, in this final rule, we are adopting as final, without modification, the proposed changes to § 412.64(d).

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase applicable to the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase 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). Because the Act sets the update factor for SCHs and MDHs equal to the update factor for all other IPPS hospitals, the update to the hospital specific rates for SCHs and MDHs is also subject to the amendments to section 1886(b)(3)(B)(i) made by section 3401(a) of the Affordable Care Act. Accordingly, for hospitals paid for their inpatient operating costs on the basis of a hospital-specific rate, the rates paid to such hospitals for discharges occurring during the first half of FY 2010 are based on an annual update estimated to be 2.1 percent for hospitals submitting quality data or 0.1 percent for hospitals that fail to submit quality data; and the rates paid to such hospitals for the second half of FY 2010 are based on an update that is estimated to be 1.85 percent for hospitals submitting quality data or −0.15 percent for hospitals that fail to submit quality data. In the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we proposed to revise §§ 412.73(c)(15), 412.75(d), 412.77(e), 412.78(e), and 412.79(d) to reflect current law. We did

not receive any public comments on this proposal. Therefore, in this final rule, we are adopting as final, without modification, the proposed changes to §§ 412.73(c)(15), 412.75(d), 412.77(e), 412.78(e), and 412.79(d).

2. FY 2011 Inpatient Hospital Update

As with the FY 2010 applicable percentage increase, sections 3401(a) and 10319(a) of the Affordable Care Act amended section 1886(b)(3)(B)(i) of the Act to provide that the FY 2011 applicable percentage increase for IPPS hospitals equals the rate-of-increase in the hospital market basket for IPPS hospitals in all areas reduced by 0.25 percentage point, subject to the hospital submitting quality data 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 minus a 0.25 percentage point less an additional 2.0 percentage points. Section 3401(a)(4) of the Affordable Care Act further states that this amendment may result in the applicable percentage increase being less than zero.

In Appendix B of the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24321), we announced that due to the timing of the passage of the Affordable Care Act, we were unable to address those provisions in the proposed rule. In that proposed rule, 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 estimated that the FY 2011 update to the operating standardized amount would 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 estimated that the update to the operating standardized amount would be 0.4 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points). In the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30923), we stated that, consistent with the amendments to section 1886(b)(3)(B)(i) of the Act made by section 3401 of the Affordable Care Act, for FY 2011 we are required to reduce the hospital market basket update by a 0.25 percentage point. Therefore, based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2011 market basket increase, the estimated update to the FY 2011 operating standardized amount was 2.15 percent (that is, the FY 2011 estimate of the market basket rate-of-increase of 2.4 percent minus 0.25 percentage point) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the estimated update to the operating standardized amount is 0.15 percent (that is, the adjusted FY 2011 estimate of the market basket rate-of-increase of 2.15 percent minus 2.0 percentage points). Since publication of the FY 2011 IPPS/LTCH PPS supplemental proposed rule, our estimate of the market basket for FY 2011 has been updated based on more recently available data. Therefore, based on IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2011 market basket increase, the update to the FY 2011 operating standardized amount is 2.35 percent (that is, the FY 2011 estimate of the market basket rate-of-increase of 2.6 percent minus 0.25 percentage point) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the update to the operating standardized amount is 0.35 percent (that is, the adjusted FY 2011 market basket rate-of-increase of 2.35 percent minus 2.0 percentage points). In the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we proposed to revise § 412.64(d) to reflect the provisions of section 3401(a) of the Affordable Care Act for FY 2011.

Comment: Some commenters opposed the reduction to the market basket by 0.25 percentage point for updating the operating standardized amounts for FY 2010 and FY 2011 that was mandated by the Affordable Care Act. The commenters believed that the reduction of payments due to the reduction of the market basket would cause serious harm to hospitals.

Response: As stated above, the reduction to the market basket for updating the operating standardized amounts is a statutory requirement that must be implemented for FY 2010 and FY 2011. Therefore, in this final rule, we are adopting as final, without modification, the proposed changes to § 412.64(d) to reflect current law.

Section 1886(b)(3)(B)(iv) of the Act provides that the FY 2011 applicable percentage increase in the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase 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). Similar to the FY 2010 applicable percentage increase in the hospital-specific rates, because the Act requires us to apply to the hospital-specific rates the update factor for all other IPPS hospitals, the update to the hospital-specific rates for SCHs and MDHs is also subject to section 1886(b)(3)(B)(i) of the Act, as amended by the Affordable Care Act. Accordingly, the update to the hospital-specific rates applicable to SCHs and MDHs for FY 2011 is 2.35 percent for hospitals that submit quality data or 0.35 percent for hospitals that fail to submit quality data. In the FY 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30923), we proposed to revise §§ 412.73(c)(15), 412.75(d), 412.77(e), 412.78(e), and 412.79(d) to incorporate these provisions.

We did not receive any public comments on this proposal. Therefore, we are adopting as final, without modification, the proposed changes to §§ 412.73(c)(15), 412.75(d), 412.77(e), 412.78(e), and 412.79(d).

3. FY 2010 and FY 2011 Puerto Rico Hospital Update

Puerto Rico hospitals are paid a blended rate for their inpatient operating costs based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. Section 1886(d)(9)(C)(i) of the Act is the basis for determining the applicable percentage increase applied to the Puerto Rico-specific standardized amount. Section 1886(d)(9)(C)(i) of the Act provides that the Puerto Rico standardized amount shall be adjusted in accordance with the final determination of the Secretary under section 1886(d)(4) of the Act. Section 1886(e)(4)(1) of the Act in turn directs the Secretary to recommend an appropriate change factor for Puerto Rico hospitals taking in to account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, as well as the recommendations of MedPAC. In order to maintain consistency between the portion of the rates paid to Puerto Rico hospitals under the IPPS based on the national standardized amount and the portion based on the Puerto Rico-specific standardized rate, beginning in FY 2004 we have set the update to the Puerto Rico-specific operating standardized amount equal to the update to the national operating standardized amount for all IPPS hospitals. This policy is reflected in our regulations at 42 CFR 412.211.

The amendments made to section 1886(b)(3)(B)(i) of the Act by sections 3401(a) and 10319(a) of the Affordable Care Act affected only the update factor

applicable to the national standardized rate for IPPS hospitals and the hospital-specific rates; they do not mandate any revisions to the update factor applicable to the Puerto Rico-specific standardized amount. Rather, as noted above, sections 1886(d)(9)(C)(i) and (e)(4) of the Act direct us to adopt an appropriate change factor for the FY 2010 Puerto Rico-specific standardized amount, which we did in the FY 2010 IPPS/LTCH PPS final rule after notice and consideration of public comments. Therefore, as we indicated in the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we do not believe we have the authority to set the FY 2010 update factor for the Puerto Rico-specific operating standardized amount for the second half of FY 2010 equal to the update factor applicable to the national standardized amount or the hospital-specific rates (that is the market basket minus a 0.25 percentage point). Accordingly, the FY 2010 update to the Puerto Rico-specific operating standardized amount is 2.1 percent (that is, the FY 2010 estimate of the market basket rate-of-increase) for the entire FY 2010.

For FY 2011, consistent with our past practice of applying the same update factor to the Puerto Rico-specific standardized amount as applied to the national standardized amount, in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30923), we proposed to revise § 412.211(c) to set the update factor for FY 2011 for the Puerto Rico-specific operating standardized amount equal to the update factor applied to the national standardized amount for all IPPS hospitals. We proposed an update factor for the Puerto Rico-specific standardized amount equal to the FY 2011 IPPS operating market basket rate-of-increase, which at that time was estimated to be 2.4 percent minus 0.25 percentage points, or 2.15 percent, for FY 2011. Since publication of the FY 2011 IPPS/LTCH PPS supplemental proposed rule, the estimate of the market basket for FY 2011 has been updated based on more recently available data. Therefore, based on the current estimate of the IPPS operating market basket rate-of-increase, the update factor for the Puerto Rico-specific standardized amount is 2.6 percent minus 0.25 percentage point, or 2.35 percent, for FY 2011. We did not receive any public comments on our proposal to revise § 412.211(c) to set the update factor for FY 2011 for the Puerto Rico-specific operating standardized amount equal to the update factor applied to the national standardized amount for all IPPS hospitals. Therefore, we are adopting as final, without modification, the proposed changes to § 412.211(c).

V. 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 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 (collectively referred to as the Affordable Care Act) affected 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 were unable to address those provisions in the FY 2011 IPPS/LTCH PPS proposed rule issued in the **Federal Register** on May 4, 2010 (75 FR 23852). On June 2, 2010, we issued a supplemental proposed rule to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30918) that included proposed policies and payment rates to implement certain provisions of the Affordable Care Act.

Although the provisions of the Affordable Care Act do not directly affect the payment rates and policies for the IPPS for capital-related costs, in section II. of the Addendum of the June 2, 2010 supplemental proposed rule, we proposed revised capital IPPS standard Federal rates for FY 2011. This was necessary because the wage index changes required by the provisions of the Affordable Care Act (discussed in section III. of this preamble) affected the proposed budget neutrality adjustment factor for changes in DRG classifications and weights and the geographic adjustment factor (GAF) (that were issued in the FY 2011 IPPS/LTCH PPS proposed rule) because the GAF values are derived from the wage index values (§ 412.316(a)). In addition, certain provisions of the Affordable Care Act also necessitated a revision to the proposed outlier payment adjustment factor that were issued in the FY 2011 IPPS/LTCH PPS proposed rule because a single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments (§ 412.312(c)). The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG 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 revised proposed capital IPPS standard Federal rates for FY 2011 were discussed in section II. of the Addendum to the June 2, 2010 supplemental proposed rule and are discussed and being finalized in section III. of the Addendum to this final rule.

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. 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 patient 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 are 747 DRGs with the finalization of our proposal in this final 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 patient 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 7−0.9 percent to the FY 2009 IPPS national standardized amounts and the capital Federal rate. The documentation and coding adjustments established in the FY 2009 IPPS final rule, as amended by Pub. L. 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent. (For additional details on the development and implementation of the documentation and coding adjustments for FY 2008 and FY 2009, we refer readers to section II.D. of this preamble and the following rules published in the **Federal Register**: August 22, 2007 (72 FR 47175 through 47186 and 47431 through 47432); November 27, 2007 (72 FR 66886 through 66888); and August 19, 2008 (73 FR 48447 through 48450 and 48773 through 48775).)

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 the FY 2011 IPPS/LTCH PPS proposed rule, we 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 (75 FR 24014). Specifically, as discussed in greater detail in section II.D.5. of the preamble of the proposed rule and this final 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 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. We also noted our intent to update our analysis with FY 2009 data on claims paid through March 2009 (sic) for this FY 2011 IPPS/LTCH PPS final rule. (We note that the March 2009 update date for claims paid data in the proposed rule should have been March 2010.) As intended, we have updated our analysis with FY 2009 data on claims paid through March 2010 in this FY 2011 IPPS/LTCH PPS final rule.

For this final rule, applying the same analysis methodology as we did for the proposed rule to an FY 2009 claims data updated through March 2010 verified the 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. As we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24014), 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). We indicated that 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.

4. 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 we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24014) and as noted above, based on our retrospective evaluation of the FY 2009 claims, our actuaries' determined 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 reduction that has already been applied to the national capital Federal rate. In that same proposed rule, we also discussed that for FY 2011, we proposed a retrospective adjustment of −2.9 percent under the authority of section 7(b)(1)(B) of Public Law 110–90. Under that proposal, although 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, we did not proposed a prospective adjustment to the IPPS operating average standardized amounts under section 7(b)(1)(A) of Public Law 110–90 for FY 2011.

Given the increase in IPPS payments that we have determined is due to documentation and coding (discussed above in this section), in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24014), we explained that we believe it is necessary and appropriate under the Secretary's broad authority under section 1886(g) of the Act, consistent 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. We also discussed that 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 transitional policies we have adopted in many similar cases and in order to maintain consistency as far as possible with the adjustments that we proposed to apply to IPPS hospitals, under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we proposed an adjustment of −2.9 percent in FY 2011 to the national capital Federal rate to account for a portion of the cumulative effect of the estimated changes in documentation and coding changes under the MS–DRG system through FY 2009 that did not reflect real changes in case-mix. We stated that we believe that this proposed adjustment would allow us to moderate the effects to hospitals in one year and to maintain equity between hospitals paid on the basis of different prospective rates. Furthermore, consistent with our proposal for the hospital-specific rates under the operating IPPS, we proposed to leave that proposed −2.9 percent adjustment in place for subsequent fiscal years to account for the effect of that documentation and coding change in subsequent years. We also sought 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 based on an analysis of 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 (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).

Comment: Several commenters opposed the proposed −2.9 percent prospective adjustment to the national capital Federal rate for FY 2011 to partially account for the cumulative effect of the estimated changes in documentation and coding changes under the MS–DRG system that did not reflect real changes in case-mix. Most of these commenters cited the potentially severe negative fiscal impact that would be experienced by providers if the proposed documentation and coding adjustment were to be implemented.

Response: We understand commenters' concern about the possible financial disruption that may be caused by the proposed documentation and coding improvement payment adjustment. However, as discussed in the FY 2011 IPPS/LTCH PPS proposed rule and reiterated above, given the increase in IPPS payments that we have determined is due to changes in documentation and coding under the MS–DRG system, we believe it is necessary and appropriate under the Secretary's broad authority under section 1886(g) of the Act, consistent 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 which have resulted in an inappropriate increase in IPPS payments. These payment adjustments are necessary to correct these past overpayments due to increases in aggregate payments that do not reflect real change in case-mix severity of illness levels, but instead are caused solely by documentation and coding improvements. In addition, we proposed a transitional implementation of the full adjustment to provide hospitals with time to adjust to future payment differences and to moderate the effect of this adjustment in any given year.

Comment: In its public comments, MedPAC discussed that "the shift to

MS–DRGs was taken to improve the distribution of payments, not change the aggregate level of payments." MedPAC performed an independent analysis of claims data to determine the effect of documentation and coding in FYs 2008 and 2009. MedPAC stated, "In our judgment, CMS's analytic methods are valid. Using similar methods, our analysis of Medicare hospital inpatient claims for 2007–2009 confirms all of CMS's findings." Consistent with our analysis, MedPAC's analysis demonstrated that the cumulative effect of documentation and coding in FY 2009 is 5.4 percent and they recommend for both the operating and capital IPPS that "overpayments should be stopped [and] all overpayment should be recovered." In making that recommendation, MedPAC directed CMS to its March 2010 Report to Congress where it recommended that Congress change the law to require CMS to recover all overpayments with interest. MedPAC noted that this would shift CMS' focus to the prevention of future overpayments in the operating and capital IPPS. Such a shift might be implemented as prospective adjustments and would result in slower accumulation of future overpayments. A detailed summary of MedPAC's comment on our proposed documentation and coding adjustments for FY 2011 for all hospitals paid under the operating and capital IPPS and our full response can be found in section II.D.7. of the preamble of this final rule.

Response: We appreciate MedPAC's independent validation and support of our methodology, which corroborates our estimate of the cumulative documentation and coding effect net of measurement error of 5.4 percent. Furthermore, we agree with MedPAC's conclusions on the overall financial implications of implementing our proposed −2.9 percent payment rate adjustment. We share MedPAC's concerns about delaying the prevention of future overpayments in both the capital and operating IPPS, but we appreciate its acknowledgment of CMS' discretion on this policy and of the potential financial disruption from implementation of the full prospective reduction in FY 2011 (−3.9 percent).

As discussed in section II.D.7. of the preamble of this final rule, after considering the public comments we received, as well as MedPAC's detailed analysis, we believe that the methodology we have employed to determine the cumulative effect of documentation and coding changes is sound. Therefore, we have decided to finalize our proposal to make an adjustment to the national capital Federal rate of −2.9 percent, which represents a portion of the remaining prospective adjustment of 3.9 percent (5.4 percent documentation and coding effect minus the 1.5 percent adjustment already applied the national capital Federal rate). The adjustment we are finalizing in this final rule is consistent with the magnitude of the retrospective adjustment of −2.9 percent that we are applying under section 7(b)(1)(B) of Public Law 110–90 to the operating IPPS standardized amount for FY 2011 (discussed in section II.D.7. of this preamble). As discussed above, while we are sympathetic to the concerns expressed by many commenters about the potential adverse financial effects on hospitals, given the increase in IPPS payments that we have determined is due to changes in documentation and coding under the MS–DRG system, as we proposed, we believe it is necessary and appropriate 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. We also believe the proposed transitional approach is a reasonable and fair way to accomplish the elimination of the full effect of these documentation and coding changes while moderating the fiscal impact on hospitals.

Therefore, in this final rule, under the Secretary's broad authority under section 1886(g) of the Act, consistent with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, as we proposed, in FY 2011 we are implementing an adjustment to the capital Federal rate of −2.9 percent to account for the effect of the estimated changes in documentation and coding changes under the MS–DRG system that occurred in FYs 2008 and 2009 that did not reflect real changes in case-mix. Furthermore, consistent with our proposal and the policy we are adopting in this final rule for the hospital-specific rates under the operating IPPS, we will leave the −2.9 percent adjustment in place for subsequent fiscal years to account for the effect of that documentation and coding change in subsequent years. As discussed in the FY 2011 IPPS/LTCH PPS proposed rule and reiterated 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 effect of documentation and coding changes under the MS–DRG system of −5.4 percent minus the existing −0.6 percent and −0.9 percent adjustments and the −2.9 percent adjustment for FY 2011).

5. 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, we 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24015), when we performed a retrospective evaluation of the FY 2009 claims data from the December 2009 update of the MedPAR file of hospitals located in Puerto Rico using the same methodology to estimate documentation and coding changes under IPPS for non-Puerto Rico hospitals, 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 FYs 2008 and 2009 from hospitals located in Puerto Rico was approximately 2.4 percent. (As discussed in section II.D.10.b. of this preamble, our updated analysis of FY 2009 claims paid through March 2010 using the same methodology as the one used for the proposed rule, shows that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FYs 2008 and 2009 from hospitals located in Puerto Rico is approximately 2.6 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 (discussed 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 that same proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, we proposed to adjust the Puerto Rico-specific capital rate by −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 proposed 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.

In the FY 2011 IPPS/LTCH PPS proposed rule, we sought public comment on the proposed prospective adjustment of −2.4 percent to Puerto Rico-specific standardized amount and the Puerto Rico-specific capital rate. We noted our intent to update our analysis with FY 2009 data on "claims paid through March 2009" (sic) for this FY 2011 IPPS/LTCH PPS final rule. (We note that the March 2009 update date for claims paid data in the proposed rule should have been March 2010.) As intended, we have updated our analysis with FY 2009 data on claims paid through March 2010 in this FY 2011 IPPS/LTCH PPS final rule, as discussed below.

As described section II.D.10.b. of this preamble, MedPAC responded to our request for comments regarding the level of adjustment for special categories of hospitals, such as Puerto Rico hospitals, by pointing out that these hospitals have the same financial incentives for documentation and coding improvements and the same ability to benefit from increased payments that do not reflect real change in case-mix. Therefore, MedPAC recommended that "all IPPS hospitals should be treated the same." At the same time, MedPAC also stateds that "delaying prevention of overpayments * * * creates a problem because overpayments will continue to accumulate in 2010 and later years until the effect of documentation and coding improvement is fully offset in the payment rates."

We agree with MedPAC that Puerto Rico hospitals have had the same financial incentives to improve documentation and coding as other IPPS hospitals. We further agree with MedPAC that it is appropriate to focus on minimizing the accumulation of overpayments; we interpret this statement to mean that MedPAC recommends that CMS should move forward as quickly as possible with appropriate prospective adjustments. We appreciate MedPAC's guidance that "all hospitals be treated the same," and we agree that it is important to treat various classes of hospitals that are similarly situated with respect to their ability to adjust their documentation and coding changes consistently in our payment policy determinations.

Therefore, consistent with the policy we are implementing to adjust the FY 2011 capital Federal rate (discussed above) and consistent with the adjustment we are establishing in FY 2011 Puerto Rico-specific standardized amount (discussed in section II.D.10.b. of this preamble), under the Secretary's broad authority under section 1886(g) of the Act, we are finalizing our proposal to adjust the Puerto Rico-specific capital rate in FY 2011 for the increase in case-mix due to changes in documentation and coding under the MS–DRGs through FY 2009. As discussed in section II.D.10.b. of this preamble and as noted above, our updated analysis of FY 2009 claims paid through March 2010 using the same methodology as the one used for the proposed rule, shows 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 2009 from hospitals located in Puerto Rico is approximately 2.6 percent. Accordingly, in this final rule, we are establishing an adjustment of −2.6 percent to the Puerto Rico-specific capital rate in FY 2011 to account for changes in case-mix due to documentation and coding that did not reflect real changes in case-mix. As we proposed, we will leave this −2.6 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 continue to believe that such an adjustment is appropriate because, as MedPAC noted, all hospitals have the same financial incentives for documentation and coding improvements, and the same ability to benefit from the resulting increase in aggregate payments that do not reflect real changes in case-mix.

As we proposed, the −2.6 percent documentation and coding adjustment that we are establishing in this final rule applies to the Puerto Rico-specific capital rate that accounts for 25 percent of capital IPPS payments to hospitals located in Puerto Rico, with the remaining 75 percent based on the national capital Federal rate, which is being further adjusted for the effects of documentation and coding as described above. Consequently, the overall reduction to the FY 2011 payment rates for hospitals located in Puerto Rico to account for documentation and coding changes is slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national capital Federal rate. As discussed 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 Changes for FY 2011

The final annual update to the capital IPPS national Federal 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 final rule.

VI. 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.)

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24016), we proposed that the rate-of-increase percentage to be applied to the target amount for cancer and children's hospitals and RNHCIs was 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. For FY 2011, we proposed to continue to use the IPPS operating 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.

In the FY 2011 IPPS/LTCH PPS we proposed to use the revised and rebased FY 2006-based IPPS operating market basket to update the target amounts for children's and cancer hospitals and RNHCIs for FY 2011. Therefore, based on IHS Global Insight, Inc.'s 2010 first quarter forecast, with historical data through the 2009 fourth quarter, we estimated that the FY 2011 update to the IPPS operating market basket would be 2.4 percent (that is, the estimate of the market basket rate-of-increase).

Consistent with our historical approach, we calculated the proposed rate-of-increase in the IPPS operating market basket for FY 2011 using the most recent data available. However, we proposed that if more recent data became available for the final rule, we would use them to calculate the IPPS operating market basket update for FY 2011. Therefore, based on IHS Global Insight's 2010 second quarter forecast, with historical data through the 2010 first quarter, the final IPPS operating market basket update factor for FY 2011 is 2.6 percent. Moreover, consistent with our proposal that the percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs would be the percentage increase in the FY 2011 IPPS operating market basket, the FY 2011 rate-of-increase percentage that is applied to the FY 2010 target amounts in order to calculate the final FY 2011 target amounts for cancer and children's hospitals and RNHCIs is 2.6 percent, in accordance with the applicable regulations in 42 CFR 413.40.

We note that IRFs, IPFs, and LTCHs, which were paid previously under the reasonable cost methodology, now receive payment under their own prospective payment systems, in accordance with changes made to the statute. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provided transition periods of varying lengths during which time a portion of the prospective payment was based on cost-based reimbursement rules under part 413. (However, certain providers do not receive a transition period or may elect to bypass the transition period as applicable under 42 CFR part 412, subparts N, O, and P.) We note that the various transition periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section IV. of the Addendum to this final rule for the specific proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for FY 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 makes an election, under section 1834(g)(2) of the Act). The physician or other practitioner providing the professional service receives payment under the Medicare Physician Fee Schedule (MPFS). In the alternative, the CAH may make an election under section 1834(g)(2) of the Act to receive amounts that are equal to the "reasonable costs" 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" or "the optional method." 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 Pub. L. 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 reasonable cost payment under the optional method at section 1834(g)(2)(A) of the Act.

Accordingly, section 1834(g) of the Act 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 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 in effect prior to implementation of section 3128 of the Affordable Care Act, under this optional method, the CAH received 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. (We refer readers to section VI.B.3. of this preamble for a discussion of the policy changes to payments for outpatient facility services made by section 3128 of the Affordable Care Act.)

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, there have been instances where 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, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24017), we proposed 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 proposed to revise the regulations to include a mechanism for CAHs that are being paid under the optional method to terminate that election. Specifically, we proposed 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 was for cost reporting periods beginning on or after October 1, 2010, we acknowledged that 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 proposed 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 would have until December 1, 2010, to terminate their prior year election. The termination would 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.

Comment: Many commenters supported the proposal that, effective for 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. The commenters stated the proposed change would reduce CAHs' administrative burdens and ensure continued access to payment under the optional method. One commenter stated its State has 77 CAHs and the proposed change would help provide continued access to the optional method. Another commenter stated that most CAHs in its

State have elected the optional method and the proposed change would save staff time and help prevent billing errors. One commenter stated approximately 72 out of 82 CAHs in its State have elected the optional method and the proposed change will help eliminate an annual administrative burden. Another commenter stated the proposed change would help ensure continued access to care in rural areas of its State.

Response: We thank the commenters for their support of the proposed provision, which we are adopting as final in this final rule.

Comment: One commenter stated that because physician bills under the traditional method (the method specified at section 1834(g)(1) of the Act) are paid by the carrier instead of by the fiscal intermediary or the MAC, the CAH should be required to inform the carrier, in addition to the fiscal intermediary or the MAC, of any billing assignment changes.

Response: In the proposed rule, we stated that in order to ensure there is no duplicate billing and that appropriate payments are made, a CAH must continue to notify its fiscal intermediary or MAC when changes in reassignment occur. We agree with the commenter that the carrier should be notified of any billing reassignment changes. Therefore, if a physician/practitioner reassignment changes such that there is a change in which physician/practitioner bills would be paid by the carrier, in addition to notifying the fiscal intermediary or MAC, the CAH must also notify the carrier. We believe this practice will help ensure appropriate payments are made to the CAH and the physician/practitioner.

Comment: Several commenters requested that CMS apply the same policy as it proposed for the CAH optional method election to hospitals redesignated under section 1886(d)(8)(B) of the Act.

Response: We did not propose any changes to the redesignation requirements. Therefore, these requests are not within the scope of this final rule. We will consider these comments as we develop future rulemaking.

Accordingly, after consideration of the public comments we received, we are adopting our proposal as final, as follows: We are adopting as final, with some technical revisions discussed below, the proposed revision of § 413.70(b)(3)(i) to specify 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 will no longer be required to make an annual election in order to continue to be paid under the optional method in a subsequent year. However, we are making some technical revisions to the proposed language of § 413.70(b)(3)(i)(A)(2) in order to state more clearly that if a CAH did not elect the optional method in its most recent preceding cost reporting period and chooses to be paid under the optional method for a cost reporting period beginning on or after October 1, 2010, it must submit a request in writing to the fiscal intermediary or MAC at least 30 days prior to the start of the cost reporting period for which the election is to be effective. Finally, we are adopting as final our revision of 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. CAHs will have until December 1, 2010, to terminate their prior year election if they have cost reporting periods beginning in October 2010 or November 2010, had elected the optional method in 2009, and wish to terminate that election in 2010. The termination will be effective for the entire FY 2011 cost reporting period.

We also are adopting as final the conforming change to § 413.70 (b)(3)(i)(D).

3. Changes in Payments to CAHs Made by the Affordable Care Act

As stated earlier in this preamble, 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. 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 costs of the CAH in providing such services. Under the optional method, described under section 1834(g)(2) of the Act, the CAH may make an election to receive amounts that are equal to "the reasonable costs" of the CAH for facility services plus, with respect to professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. 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.

Section 1834(l)(8), as added by section 205 of Public Law 106–554, establishes the payment methodology for ambulance services furnished by a CAH or by an entity that is owned and operated by a CAH. This provision states that payment is made based on the reasonable costs incurred in furnishing ambulance services if such services are furnished by a CAH (as defined in section 1861(mm)(1) of the Act), or by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

Section 3128(a) of the Affordable Care Act amended sections 1834(g)(2)(A) and 1834(l)(8) of the Act by inserting "101 percent of" before "the reasonable costs." As such, section 3128(a) increases payment for outpatient facility services under the optional method and payment for ambulance services furnished by a CAH or an entity owned and operated by a CAH, to 101 percent of reasonable costs. Section 3128(b) of the Affordable Care Act states that the amendments made under section 3128(a) shall take effect as if they were included in the enactment of section 405(a) of Public Law 108–173. Section 405(a) of Public Law 108–173 provided that, in general, inpatient, outpatient, and covered SNF services provided by a CAH would be reimbursed at 101 percent of reasonable costs, and was applicable to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

Because of the date of enactment of the Affordable Care Act, we were unable to include these provisions in the FY 2011 IPPS/LTCH PPS proposed rule. Therefore, in a separate supplemental proposed rule which appeared in the **Federal Register** on June 2, 2010 (75 FR 30965), we included proposals to implement the changes made by section 3128. The final policies discussed below take into consideration public comments that we received on the supplemental proposed rule.

In order to implement section 3128 of the Affordable Care Act, in the supplemental proposed rule, we

proposed to amend the regulations at § 413.70(b)(3)(ii)(A) to state that, effective for cost reporting periods beginning on or after January 1, 2004, under the optional method, payment for facility services will be made at 101 percent of reasonable costs. Accordingly, regardless of whether a physician or practitioner has reassigned his or her billing rights to the CAH, payment for CAH facility services would be made at 101 percent of reasonable costs. In addition, we proposed to implement the change in payment for ambulance services provided by section 3128 of the Affordable Care Act by amending the regulations at § 413.70(b)(5)(i) to state that, effective for cost reporting periods beginning on or after January 1, 2004, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

Comment: Several commenters supported the proposed provisions implementing section 3128 of the Affordable Care Act. One commenter stated that, in Iowa, there are 82 CAHs and 72 of them have elected to be paid under the optional method. The commenter stated the proposed provision will have a positive impact on these small hospitals.

Another commenter disagreed with CMS' finalized policy in the FY 2010 IPPS/LTCH PPS final rule, which reduced payment for CAH facility services under the optional method to 100 percent of reasonable costs. The commenter had requested CMS "* * * to reference the MMA conference report which clearly indicated that Congress intended to set all CAH outpatient reimbursement at 101 percent of reasonable cost." The commenter further stated that, as part of the supplemental proposed rule, "CMS proposed to restore 101 percent of cost-based reimbursement for CAHs election Method II billing, and is proposing to extend this change retroactively to FFY 2010."

Response: We appreciate the commenters' support of the proposed implementation of the provision to increase payment for CAH outpatient facility services paid under the optional method and increase payment for CAH ambulance services to 101 percent of reasonable costs. In the response to the commenter who stated we were proposing to extend this change retroactively to FY 2010, we note that we proposed to make this change in payment to 101 percent of reasonable costs effective for cost reporting periods beginning on or after January 1, 2004, to conform to the requirements of section 3128(b) of the Affordable Care Act.

After consideration of the public comments we received, we are adopting our proposed revisions to the regulations at §§ 413.70(b)(3)(ii)(A) and 413.70(b)(5)(i) as final, without modification. Accordingly, effective for cost reporting periods beginning on or after January 1, 2004, CAHs that are paid under the optional method will be paid based on 101 percent of reasonable costs for outpatient facility services and all CAHs will be paid based on 101 percent of reasonable cost for ambulance services. We note that, as we indicated in the proposed rule, we do not believe these revisions will result in additional payments to CAHs for prior periods because we believe, in fact, that CMS has paid CAHs for these services at 101 percent of reasonable costs during these prior periods.

4. 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, Part 1 (PRM–1) for determining allowable reasonable costs under Medicare. Specifically, section 2122 of the PRM–1 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–1 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–1 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. However, they are not 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. Clarification of Payment Policy for Provider Taxes

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24019), we stated that 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–1 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–1 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.

Therefore, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24018), we proposed 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 were 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, we stated that this policy clarification could impact certain providers that are paid on the basis of their incurred reasonable costs, such as CAHs. Therefore, we proposed to clarify the policy set forth in sections 2122.1 and 2122.2 of the PRM–1 to reflect our concerns set forth above regarding when certain provider taxes may be allowable costs under the Medicare program.

Comment: Commenters disagreed with our statement that the provision in the proposed rule was a clarification in policy. They expressed concern that the provision was a policy change that could be applied retroactively and could potentially have serious negative fiscal impact. A number of commenters also raised concern that the language in the proposed rule did not clearly articulate the revisions to the PRM and is vague regarding when certain provider taxes may be allowable. Specifically, the commenters were concerned that Medicare would not reimburse the cost of these taxes. Specifically, the commenters were concerned that the payment of the net expense of a provider tax, as reported on a CAH's Medicare cost report, would have a negative financial impact on the CAH.

Response: We believe that this provision, as articulated in the proposed rule, is a clarification of our current, longstanding policy which requires that "reasonable costs" claimed by providers must be "actually incurred." Currently, CMS and its Medicare contractors apply the longstanding reasonable cost principles at section 1861(v)(1)(A) of the Act and at 42 CFR 413.9 of the regulations to determine if a particular expense is an allowable cost under Medicare. One such principle, as discussed above, is that a "reasonable cost" must be "actually incurred."

We disagree that sections 2122.1 and 2122.2 of the PRM–1 take a contrary position. The discussion of taxes and allowable costs in the PRM–1 does not specifically address the requirement that costs must be "actually incurred." However, the discussion of provider taxes in the PRM–1 should be considered in conjunction with the reasonable costs requirements set forth in the statute and regulations. To the extent that providers considered the list in section 2122.2 of the PRM–1 to permit a facility from counting, as part of its allowable costs, all but the listed provider taxes, regardless of whether the taxes listed were "actually incurred," we are now clarifying that this approach is inconsistent with reasonable cost principles.

We believe that it is consistent with the current and longstanding principles of cost reimbursement, as set forth in the statute and regulations, to remind both providers and our contractors, that although a particular tax may be an allowable cost, the amount of that tax that providers may claim for reasonable cost purposes, must reflect the amount of these assessed taxes that are actually incurred. Thus, in accordance with the Medicare statute, regulations, and PRM policies, Medicare contractors will continue to apply the current reasonable cost principles to determine if a provider tax incurred is an allowable cost and how much of that allowable cost is actually incurred to determine reimbursement.

As stated in the proposed rule, we intended to address the potential confusion that arises when providers interpret sections of the PRM–1 to allow taxes assessed against a provider that are not specifically listed in section 2122.2, regardless of whether those costs are actually incurred. We believe that clarifying the PRM–1 to explain that the list of taxes is only an example of the enumerated taxes is consistent with the current and longstanding reasonable cost principles. Moreover, to the extent that a particular tax might be an allowable expense, it still must be "actually incurred."

This clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding

reasonable cost principles. In addition, the Medicare contractors will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax.

After consideration of the public comments we received, we are adopting our proposed clarification, as final, without modification. We will modify section 2122 of the PRM–1 to specifically reference our current, longstanding reasonable cost principles.

C. Report of Adjustment (Exceptions) Payments

Section 4419(b) of Public Law 105–33 requires the Secretary to publish annually in the Federal Register a report describing the total amount of adjustment payments made to excluded hospitals and hospital units by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

The process of requesting, adjusting, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, generally, an excluded hospital or an excluded unit of a hospital must file its cost report for a fiscal year in accordance with § 413.24(f)(2). The fiscal intermediary or MAC reviews the cost report and issues a notice of program reimbursement (NPR). Once the hospital receives the NPR, if its operating costs are in excess of the ceiling, the hospital or hospital unit may file a request for an adjustment payment. After the fiscal intermediary or MAC receives the hospital's or hospital unit's request in accordance with applicable regulations, the fiscal intermediary or MAC or CMS, depending on the type of adjustment requested, reviews the request and determines if an adjustment payment is warranted. This determination is sometimes not made until more than 6 months after the date the request is filed because there are times when the applications are incomplete and additional information must be requested in order to have a completed application. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustment payments that were processed by the fiscal intermediary or MAC or CMS during FY 2009.

The table below includes the most recent data available from the fiscal intermediaries or MACs and CMS on adjustment payments that were adjudicated during FY 2009. As indicated above, the adjustments made during FY 2009 only pertain to cost reporting periods ending in years prior to FY 2008. Total adjustment payments given to excluded hospitals and hospital units during FY 2009 are $7,824,339. The table depicts for each class of hospitals, in the aggregate, the number of adjustment requests adjudicated, the excess operating costs over the ceiling, and the amount of the adjustment payments.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Psychiatric	4	$2,878,357	$1,396,564
Children's	3	1,414,635	902,889
Cancer	2	12,949,901	4,753,072
Religious Nonmedical Health Care Institution (RNHCI)	7	1,570,555	771,814
Total	.....	.....	7,824,339

VII. 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). For the initial implementation of the LTCH PPS (FYs 2003) through FY 2007, the system used information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC–DRGs) based on clinical characteristics and expected resource needs. Beginning in FY 2008, we adopted the Medicare Severity-long-term care diagnosis-related groups (MS–LTC–DRGs) as the patient classification system used under the LTCH PPS. 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 the RY 2009 LTCH PPS final rule (73 FR 26797 through 26798), 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.

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 Pub. L. 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 addressed 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 Pub. L. 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 address this public comment and finalize the interim final rule with comment period in section VII.F. of the preamble of this final rule.

As discussed in section I.C. of this preamble, a number of the provisions of the Affordable Care Act affected the policies, payment rates and factors under the LTCH PPS. Due to the timing of the passage of the legislation, we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, and some of the proposed policies and payment rates in that proposed rule did not reflect the new legislation. On June 2, 2010, we issued a FY 2011 IPPS/LTCH PPS supplemental proposed rule that addressed the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2011 under the LTCH PPS. In this final rule, we address both the provisions of the May 4, 2010 proposed rule and the June 2, 2010 supplemental proposed rule and respond to public comments received.

2. Criteria for Classification as a LTCH

a. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) of greater than 25 days. Alternatively, § 412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

b. Hospitals Excluded From the LTCH PPS

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and therefore, are not subject to the LTCH PPS rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) (42 U.S.C. 1395b–1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

3. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, if the Medicare payment to the LTCH is the full LTC–DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a). However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the SSO threshold is exceeded. Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC–DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

4. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services "for which a claim is submitted other than in an electronic form specified by the Secretary." Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial "in such unusual cases as the Secretary finds appropriate" (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic healthcare transactions according to the applicable transactions and code sets standards.

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

1. Background

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

When the LTCH PPS was implemented for cost reporting periods

beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the "long-term care diagnosis-related groups (LTC–DRGs)." Although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect "the differences in patient resource use * * *" of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113)).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development and implementation 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 finalizing our proposal 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 final rule. This results 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 final rule, however, as proposed, we are establishing that, for claims submitted on the 5010 format beginning January 1, 2011, we will 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 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. 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 final rule, as was proposed we are updating the MS–LTC–DRG classifications effective October 1, 2010, through September 30, 2011 (FY 2011) consistent with the changes to specific MS–DRG classifications presented above in section II.G. of this final rule (that is, GROUPER Version 28.0). Therefore, the MS–LTC–DRGs for FY 2011 presented in this final rule are the same as the MS–DRGs that will be used under the IPPS for FY 2011. In addition, because the MS–LTC–DRGs for FY 2011 are the same as the MS–DRGs for FY 2011, the other changes that 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 final rule, including the changes to the MCE software and changes to the ICD–9–CM coding system, are also applicable under the LTCH PPS for FY 2011.

3. Development of the 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 FY 2011 MS–LTC–DRG relative weights in this final rule continues to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as

cases in an MS–LTC–DRG with a relative weight of 1.

b. Development of the 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 § 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 (RY 2008 LTCH PPS final rule (May 11, 2007; 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).) As was proposed, for this final rule the 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 both the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24023 through 24043) and the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30970 and 30971), we proposed to calculate the proposed MS–LTC–DRG relative weights for FY 2011 using total charges from FY 2009 Medicare LTCH bill data from the December 2009 update of the FY 2009 MedPAR file, which were the best available data at that time, and to use the proposed Version 28.0 of the GROUPER to classify LTCH cases. We also proposed 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.

In this final rule, to calculate the MS–LTC–DRG relative weights for FY 2011, we obtained total charges from FY 2009 Medicare LTCH bill data from the March 2010 update of the MedPAR file, which are the best available data at this time, and used the final Version 28.0 of the GROUPER to classify LTCH cases.

Consistent with our historical methodology, we proposed to exclude 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 proposed 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 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). We received one comment on these proposals. Therefore, in the development of the FY 2011 MS–LTC–DRG relative weights in this final rule, as we proposed, 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.

Comment: One commenter expressed concern that the proposed FY 2011 MS–LTC–DRG relative weights were computed using covered charges instead of total charges. The commenter requested that CMS explain the rationale if it changed its methodology for computing the MS–LTC–DRG relative weights using covered charges.

Response: When we implemented the LTCH PPS in the FY 2003 LTCH PPS final rule (67 FR 55984), we established a policy of determining the LTC–DRG relative weights and average length of stay based on total charges and total days. Consistent with our established policy, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24024), we proposed to calculate the proposed MS–LTC–DRG relative weights for FY 2011 using "total" charges from FY 2009 Medicare LTCH bill data from the MedPAR file. We did not change our methodology and we have verified that the proposed FY 2011 MS–LTC–DRG relative weights were calculated using total charges, not covered charges. Furthermore, as stated above, the FY 2011 MS–LTC–DRG relative weights established in this final rule were calculated using total charges.

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, as we proposed, we continue to use a hospital-specific relative value (HSRV) methodology to calculate the 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 reduce the impact of the variation in charges across providers on any particular MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

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

For purposes of determining the 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 relative weight; low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs that contain between 1 and 24 cases based on a given year's claims data) are grouped into quintiles (as described below) and assigned the relative weight of the quintile. No-volume MS–LTC–DRGs (that is, no cases in the given year's claims data were assigned to those MS–LTC–DRGs) are cross-walked to other MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the cross-walked 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 final rule and for no-volume MS–LTC–DRGs, under Step 5 in section VII.B.3.g. of the preamble of this final 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, as we proposed, we used the following steps to determine the FY 2011 MS–LTC–DRG relative weights: (1) If a MS–LTC–DRG has at least 25 cases, it is assigned its own relative weight; (2) if a MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we compute a relative weight for all of the MS–LTC–DRGs assigned to that quintile; and (3) if a MS–LTC–DRG has no cases, it is cross-walked to another MS–LTC–DRG based upon clinical similarities to assign an appropriate relative weight (as described below in detail in Step 5 of section VII.B.3.g. of this preamble). Furthermore, in determining the FY 2011 MS–LTC–DRG relative weights, when necessary, as we proposed, we made 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 MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with our existing methodology and as we proposed, for purposes of determining the MS–LTC–DRG relative weights, we continue to employ the quintile methodology for low-volume 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 FY 2011 MS–LTC–DRG relative weights in this final rule, in cases where the initial assignment of a low-volume MS–LTC–DRG to quintiles resulted in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology and as we proposed, we made adjustments to the treatment of low-volume MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VII.B.3.g. (Step 6) in this preamble.

In this final rule, using LTCH cases from the March 2010 update of the FY 2009 MedPAR file, we identified 283 MS–LTC–DRGs that contained between 1 and 24 cases. This list of MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 56 MS–LTC–DRGs (283/5 = 56 with 3 MS–LTC–DRG as the remainder). We assigned a low-volume MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Furthermore, because the number of MS–LTC–DRGs with less than 25 cases was not evenly divisible by 5, the average charge of the low-volume quintile was used to determine which of the low-volume quintiles would contain the 3 additional low-volume MS–LTC–DRGs. Specifically, after organizing the MS–LTC–DRGs by ascending order by average charge, we assigned the first fifth (1st through 56th) of low-volume MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The MS–LTC–DRGs with the highest average charge cases are assigned into Quintile 5. Because the average charge of the 57th low-volume MS–LTC–DRG in the sorted list is closer to the average charge of the 56th low-volume MS–LTC–DRG (assigned to Quintile 1) than to the average charge of the 58th low-volume MS–LTC–DRG (assigned to Quintile 2), we assigned it to Quintile 1 (such that Quintile 1 contains 57 low-volume MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This process was repeated through the remaining low-volume MS–LTC–DRGs so that 2 of the 5 low-volume quintiles contain 56 MS–LTC–DRGs (Quintiles 4 and 5) and the other 3 low-volume quintiles contain 57 MS–LTC–DRGs (Quintiles 1, 2, and 3).

Accordingly, in order to determine the FY 2011 relative weights for the MS–LTC–DRGs with low volume, we used 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 FY 2011 MS–LTC–DRG relative weights (as shown in Table 11 of the Addendum to this final rule). We determined a relative weight and (geometric) average length of stay for each of the 5 low-volume quintiles using the methodology that we applied to the MS–LTC–DRGs (25 or more cases), as described in section VII.B.3.g. of the preamble of this final rule. We assigned the same relative weight and average length of stay to each of the low-volume MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We used the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the relative weights based on our methodology.

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Composition of Low-Volume Quintiles for FY 2011*

MS-LTC-DRG	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
436	Malignancy of hepatobiliary system or pancreas w CC
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
598	Malignant breast disorders w CC
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
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
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
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
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
882	Neuroses except depressive
883	Disorders of personality & impulse control
903	Wound debridements for injuries w/o CC/MCC
905	Skin grafts 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
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
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC
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
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
922	Other injury, poisoning & toxic effect diag w MCC
928	Full thickness burn w skin graft or inhal inj w CC/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
358	Other digestive system O.R. procedures w/o CC/MCC
380	Complicated peptic ulcer w MCC
406	Pancreas, liver & shunt procedures 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
492	Lower extrem & humer proc except hip,foot,femur w MCC
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
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC

963	Other multiple significant trauma w MCC
964	Other multiple significant trauma w CC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC
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
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
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 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 low volume quintile assignments to address nonmonotonicity are identified in Table 11 of the Addendum of this final 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 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 FY 2011 MS–LTC–DRG Relative Weights

In the FY 2011 IPPS/LTCH PPS proposed and supplemental proposed rules, we proposed, in general, to determine the FY 2011 MS–LTC–DRG relative weights based on our existing methodology. We received no comment on this proposal and are adopting it as final in this final rule. 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 FY 2011 MS–LTC–DRG relative weights, we grouped LTCH cases to the appropriate MS–LTC–DRG, while taking into account the low-volume MS–LTC–DRGs (as described above). After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculated the 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 adjusted the number of cases in each 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 were then used to calculate "relative adjusted weights" for each MS–LTC–DRG (or low-volume quintile) using the HSRV method.

Below we discuss in detail the steps for calculating the FY 2011 MS–LTC–DRG relative weights. We received no comments on our proposed steps for calculating the FY 2011 MS–LTC–DRG relative weights. Therefore, for the reasons described above, we are employing our proposed methodology to calculate the FY 2011 MS–LTC–DRG relative weights discussed below. 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 FY 2011 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the MS–LTC–DRGs. (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 FY 2011 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the FY 2011 MS–LTC–DRG relative weights, as proposed, we removed 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 FY 2011 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, as proposed, we adjusted each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503).

We 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 RY 2011 MS–LTC–DRG relative weights would lower the 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, as proposed, we 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 FY 2011 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we calculate the 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.

As proposed, for each MS–LTC–DRG, the FY 2011 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) was calculated by dividing the sum of all the LTCH's MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above were multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values were then used to calculate a new set of MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there was convergence between the weights produced at adjacent steps, for example, when the maximum difference was less than 0.0001.

Step 5—Determine a FY 2011 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, as proposed, we determined the FY 2011 relative weight for each MS–LTC–DRG using total Medicare allowable total charges reported in the best available LTCH claims data (that is, the March 2010 update of the FY 2009 MedPAR file for this final rule). Using these data, we identified a number of MS–LTC–DRGs for which there were no LTCH cases in the database, such that no patients who would have been classified to those MS–LTC–DRGs were treated in LTCHs during FY 2009 and, therefore, no charge data were available for these MS–LTC–DRGs. Thus, in the process of determining the MS–LTC–DRG relative weights, we were unable to calculate relative weights for the MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, as proposed, we assigned a relative weight to each of the no-volume MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of "transplant" MS–LTC–DRGs and "error" MS–LTC–DRGs, as discussed below). (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 FY 2011 relative weights for the MS–LTC–DRGs with no LTCH cases in the FY 2009 MedPAR file used in this final rule (that is, "no-volume" MS–LTC–DRGs) by cross-walking each no-volume MS–LTC–DRG to another MS–LTC–DRG with a calculated relative weight (determined in accordance with the methodology described above). Then, the "no-volume" MS–LTC–DRG was assigned the same relative weight (and average length of stay) of the MS–LTC–DRG to which it was cross-walked (as described in greater detail below).

Of the 747 MS–LTC–DRGs for FY 2011, we identified 223 MS–LTC–DRGs for which there were no LTCH cases in the database (including the 8 "transplant" MS–LTC–DRGs and 2 "error" MS–LTC–DRGs). As stated above, as proposed, for this final rule we assigned relative weights for each of the 213 no-volume MS–LTC–DRGs (with the exception of the 8 "transplant" MS–LTC–DRGs and the 2 "error" MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 524 (747 − 223 = 524) MS–LTC–DRGs for which we were able to determine relative weights based on FY 2009 LTCH claims data using the steps described above. (For the remainder of this discussion, we refer to the "cross-walked" MS–LTC–DRGs as the MS–LTC–DRGs to which we crosswalk one of the 213 "no volume" MS–LTC–DRGs for purposes of determining a relative weight.) Then, we assigned the no-volume MS–LTC–DRG the relative weight of the cross-walked MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

For this final rule, there are the same 213 "no volume" MS–LTC–DRGs that there were in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24036 through 24041). We did not receive any public comments on our proposed methodology for determining FY 2011 relative weights for these no-volume MS–LTC–DRGs and, therefore, for the reasons described above, we are adopting it as final. For reference, below we describe the methodology that was used to determine FY 2011 relative weights for the no-volume MS–LTC–DRGs. We crosswalked the no-volume MS–LTC–DRG to a MS–LTC–DRG for which there were LTCH cases in the FY 2009 MedPAR file and to which it was similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We evaluated the relative costliness in determining the applicable MS–LTC–DRG to which a no-volume MS–LTC–DRG was cross-walked in order to assign an appropriate 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 MS–LTC–DRGs in FY 2011, the relative weights assigned based on the cross-walked MS–LTC–DRGs would result in an appropriate LTCH PPS payment because the crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use.

We then assigned the relative weight of the cross-walked MS–LTC–DRG as the relative weight for the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the cross-walked MS–LTC–DRG) have the same relative weight for FY 2011. We note that if the cross-walked MS–LTC–DRG had 25 cases or more, its relative weight, which was calculated using the methodology described in Steps 1 through 4 above, was assigned to the no-volume MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume MS–LTC–DRG is cross-walked had 24 or less cases and, therefore, was designated to one of the low-volume quintiles for purposes of determining the relative weights, we assigned the relative weight of the applicable low-volume quintile to the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the cross-walked MS–LTC–DRG) have the same relative weight for FY 2011. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume MS–LTC–DRG results, additional adjustments as described in Step 6 are required in order to maintain monotonically increasing relative weights.)

For this final rule, a list of the no-volume MS–LTC–DRGs and the MS–LTC–DRG to which it is cross-walked (that is, the cross-walked MS–LTC–DRG) for FY 2011 is shown in the chart below.

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No-Volume MS-LTC-DRG Crosswalk for FY 2011

MS-LTC-DRG	MS-LTC-DRG Description	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
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

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
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
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

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
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
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

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
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
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

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
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
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 relative weights for the FY 2011 MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume MS–LTC–DRGs crosswalk information for FY 2011 provided in the chart above.

Example: There were no cases in the FY 2009 MedPAR file used for this final rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that MS–LTC–DRG 70 (Nonspecific Cebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same relative weight of MS–LTC–DRG 70 of 0.9165 for FY 2011 to MS–LTC–DRG 61 (Table 11 of the Addendum to this final rule).

Again, we note that, as this system is dynamic, it is entirely possible that the

number of MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no-volume MS–LTC–DRGs and to determine the relative weights in this final rule.

Furthermore, for FY 2011, consistent with our historical relative weight methodology and as we proposed, we established MS–LTC–DRG relative weights of 0.0000 for the following transplant MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (MS–LTC–DRG 5); Liver Transplant without MCC (MS–LTC–DRG 6); Lung Transplant (MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (MS–LTC–DRG 8); Pancreas Transplant (MS–LTC–DRG 10); and Kidney Transplant (MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. At the present time, we 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).)

Step 6—Adjust the 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 DRG with CC/MCC and the DRG without CC/MCC. Alternatively, the other type of two-level subdivision may consist of the DRG with MCC and the DRG 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 FY 2011 MS–LTC–DRG relative weights in this rule, consistent with our historical methodology and as we proposed, we combined MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity 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 FY 2011 MS–LTC–DRG relative weights in this final rule by applying this methodology are denoted in Table 11 of the Addendum to this final rule.

Step 7—Calculate the 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 for the annual update of 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, in both the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24042 through 24043) and the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30970 through 30971), we proposed to update the 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 FY 2011 MS–LTC–DRG relative weights.

Comment: One commenter objected to the budget neutrality requirement for the annual update to the MS–LTC–DRG relative weights. The commenter asserted that LTCHs with high acuity patients are being penalized because of the growth in lower acuity cases, and that CMS' budget neutrality methodology dilutes the LTCH aggregate case-mix from year-to-year.

Response: We disagree with the commenter that our budget neutrality methodology dilutes a LTCH's case-mix or that LTCHs with more resource-intensive cases are being penalized because of the growth in lower resource-intensive cases. By definition, the MS–LTC–DRG relative weights "reflect the estimated relative cost of hospital resources used with that group compared to discharges classified within other groups" (§ 412.515). Thus, the relative weights themselves are not intended to increase or decrease aggregate payments under the LTCH PPS. If in fact there is growth in less intensive, lower acuity cases, then our established budget neutrality methodology would act to increase the

relative weights for all MS–LTC–DRGs. This is because under our established budget neutrality methodology, each MS LTC DRG relative weight is uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected. As we discussed when we established the budget neutrality requirement for the annual update of the MS–LTC–DRG classifications and relative weights, we believe the LTC–DRG relative weights should reflect the true costs of treating LTCH patients and should be updated annually, based on the latest available data, to reflect relative LTCH resource without affecting aggregate LTCH PPS (72 FR 26881 through 26883). For these reasons, we continue to believe that it is appropriate to update the MS–LTC–DRG classifications and relative weights in a budget neutral manner, and are not modifying our existing budget neutrality requirement or methodology in this final rule.

As noted above, in section VII.A.1. of this preamble, a number of the provisions of the Affordable Care Act affected the policies, payment rates and factors under the LTCH PPS. Due to the timing of the passage of the legislation, we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, and the proposed policies and payment rates in that proposed rule did not reflect the new legislation. On June 2, 2010, we issued a FY 2011 IPPS/LTCH PPS supplemental proposed rule that addressed the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2011 under the LTCH PPS. In that supplemental proposed rule, we proposed a standard Federal rate for FY 2011 that incorporates the "other adjustment" required in section 1886(m)(3)(A)(ii) as amended and described in section 1886(m)(4) as amended. This revision to the proposed standard Federal rate for FY 2011 also required us to revise the proposed relative weights for the MS–LTC–DRGs for FY 2011 since our established methodology for updating the annual update to the MS–LTC–DRG classifications and relative weights in a budget neutral manner requires that estimated aggregate LTCH PPS payments would be unaffected. That is, under the budget neutrality requirement estimated aggregate LTCH PPS payments 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. (75 FR 30970)

To ensure budget neutrality in the update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), in both the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24042 through 24043) and the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30970 through 30971), we proposed to continue to use our established two-step budget neutrality methodology. We received no specific comments on our proposal to continue to apply our established two-step budget neutrality methodology in determining the FY 2011 MS–LTC–DRG relative weights. Therefore, we are adopting it in this final rule. In this final rule, in the first step of our MS–LTC–DRG budget neutrality methodology, we calculated and applied a normalization factor to the 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 MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases the average CMI.

To calculate the normalization factor for FY 2011 (the first step of our budget neutrality methodology), we used the following three steps: (1.a.) We used the most recent available LTCH claims data (FY 2009) and grouped them using the FY 2011 GROUPER (Version 28.0) and the recalibrated FY 2011 MS–LTC–DRG relative weights (determined in steps 1 through 6 of the Steps for Determining the FY 2011 MS–LTC–DRG Relative Weights above) to calculate the average CMI; (1.b.) we grouped the same LTCH claims data (FY 2009) using the FY 2010 GROUPER (Version 27.0) and FY 2010 MS–LTC–DRG relative weights and calculated the average CMI; and (1.c) we computed 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 MS–LTC–DRG relative weights for FY 2011, each recalibrated MS–LTC–DRG relative weight was multiplied by 1.10382 in the first step of the budget neutrality methodology, which produced "normalized relative weights."

In this final rule, in the second step of our MS–LTC–DRG budget neutrality methodology, we determined a budget neutrality factor to ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (that is, the 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 used 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 FY 2011 MS–LTC–DRGs and relative weights. Furthermore, consistent with our historical policy of using the best available data, we used the most recently available claims data for determining the budget neutrality adjustment factor in the final rule, that is, data from the March 2010 update of the FY 2009 MedPAR file.

For this final rule, we determined the FY 2011 budget neutrality adjustment factor using the following three steps: (2.a.) We simulated estimated total LTCH PPS payments using the normalized relative weights for FY 2011 and GROUPER Version 28.0 (as described above); (2.b.) we simulated 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 calculated 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 FY 2011 GROUPER (Version 28.0) and the normalized MS–LTC–DRG relative weights for FY 2011 (determined in Step 2.a.). In determining the FY 2011 MS–LTC–DRG relative weights, each normalized relative weight was multiplied by a budget neutrality factor of 0.988124 in the second step of the budget neutrality methodology to determine the budget neutral FY 2011 relative weight for each MS–LTC–DRG.

Accordingly, in determining the FY 2011 MS–LTC–DRG relative weights in this final rule, consistent with our existing methodology and as we proposed, we applied a normalization factor of 1.10382 and a budget neutrality factor of 0.988124 (computed as described above). Table 11 in the Addendum to this final rule lists the MS–LTC–DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining SSO payments under

§ 412.529) for FY 2011. The FY 2011 MS–LTC–DRG relative weights in Table 11 in the Addendum to this final rule reflect both the normalization factor of 1.10382 and the budget neutrality factor of 0.988124.

C. 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 will be used to update the LTCH PPS standard Federal rate for FY 2011, that is, 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). 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 update to the LTCH PPS standard Federal rate for FY 2011 is presented in section V.A. of the Addendum to this final rule. The two components of the 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. Revision of Certain Market Basket Updates as Required by the Affordable Care Act

As discussed in the FY 2011 IPPS/LTCH PPS supplemental proposed rule issued on June 2, 2010 (75 FR 30965 through 30971), several provisions of the Affordable Care Act affected the policies and payment rates for RY 2010 and FY 2011 under the LTCH PPS. Section 1886(m)(3)(A)(ii) of the Act, as added by section 3401(c) of the Affordable Care Act, specifies that for each of rate years 2010 through 2019, any annual update to the standard Federal rate shall be reduced by the other adjustment specified in new section 1886(m)(4) of the Act. Furthermore, section 1886(m)(3)(A)(i) of the Act specifies that, for rate year 2012 and subsequent rate years, any annual update to the standard Federal rate shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(m)(3)(A)(ii) and sections 1886(m)(4)(A) and (B) of the Act require a 0.25 percentage point reduction for rate year 2010 and a 0.50 percentage point reduction for rate year 2011. Section 1886(m)(3)(B) of the Act provides that the application of paragraph (3) of section 1886(m) of the Act may result in the annual update being less than zero for a rate year, and may result in payment rates for a rate year being less than such payment rates for the preceding rate year. Furthermore, section 3401(p) of the Affordable Care Act specifies that the amendments made by section 3401(c) of such Act shall not apply to discharges occurring before April 1, 2010. (75 FR 30968 through 30971)

We note that in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24026 through 24027), since the annual update to the LTCH PPS policies, rates and factors now occurs on October 1, we proposed to adopt the term "fiscal year" (FY) rather than "rate year" (RY) under the LTCH PPS beginning October 1, 2010, to conform with the standard definition of the Federal fiscal year (October 1 through September 30) used by other PPSs, such as the IPPS. Consequently, in that proposed rule and in the FY 2011 IPPS/LTCH PPS supplemental proposed rule, for purposes of clarity, when discussing the annual update for the LTCH PPS, we employed "fiscal year" rather than "rate year" because it is our intent that the phrase "fiscal year" be used prospectively in all circumstances dealing with the LTCH PPS. Similarly, although the language of section 3401(c) and section 10319 and section 1105(b) of the Affordable Care Act refer to years 2010 and thereafter under the LTCH PPS as "rate year," consistent with our proposal to change the terminology used under the LTCH PPS from "rate year" to "fiscal year," for purposes of clarity, in both the FY 2011 IPPS/LTCH PPS proposed and supplemental proposed rules, when discussing the annual update for the LTCH PPS, including the provisions of the Affordable Care Act, we employed "fiscal year" rather than "rate year" for 2011 and subsequent years because it is our intent that "fiscal year" be used prospectively in all circumstances dealing with the LTCH PPS. (As discussed below in VII.D. of this preamble, we are finalizing our

proposal to adopt the term "fiscal year" (FY) rather than "rate year" (RY) under the LTCH PPS beginning October 1, 2010. Therefore, in this final rule, we employ "fiscal year" rather than "rate year" for 2011 and subsequent years in all circumstances dealing with the LTCH PPS.)

c. Change to Reflect the Market Basket Update for LTCHs for RY 2010 (§ 412.523(c)(3)(vi))

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule appearing in the **Federal Register** on August 27, 2009 (74 FR 43754), we established policies, payment rates and factors for determining payments under the LTCH PPS for RY 2010 (October 1, 2009 through September 30, 2010). Several provisions of the Affordable Care Act affected some of the policies, payment rates, and factors for determining payments under the LTCH PPS for RY 2010. In a notice issued on June 2, 2010 in the **Federal Register** (75 FR 31128 through 31130), we established revised RY 2010 LTCH PPS rates and factors consistent with the provisions of sections 1886(m)(3) and (4) of the Act, as added and amended by sections 3401(c), 3401(p), 10319(b), and 1105(b) of the Affordable Care Act. Section 1886(m)(3)(A)(ii) of the Act provides for each of RYs 2010 through 2019, the annual update to the standard Federal rate is reduced by the "other adjustment" described in section 1886(m)(4) of the Act. Specifically, sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act require a 0.25 percentage point reduction to the annual update to the standard Federal rate for RY 2010. Section 1886(m)(3)(A) of the Act, on its face, explicitly provides for a revised annual update to the standard Federal rate beginning RY 2010, thus resulting in a single revised RY 2010 standard Federal rate. Section 3401(p) of the Affordable Care Act provides that, notwithstanding the previous provisions of this section, the amendments made by subsections (a), (c) and (d) shall not apply to discharges occurring before April 1, 2010. When read in conjunction, we believe section 1886(m)(3)(A) of the Act and section 3401(p) of the Affordable Care Act provide for a single revised RY 2010 standard Federal rate. However, for payment purposes, discharges occurring on or after October 1, 2009 and before April 1, 2010, simply will not be based on the revised RY 2010 standard Federal rate.

As discussed in the June 2, 2010 **Federal Register** notice (75 FR 31128 through 31129), consistent with our historical practice and the methodology used in the FY 2010 IPPS/RY 2010 final rule, we announced an update to the LTCH PPS standard Federal rate for RY 2010 of 1.74 percent. This annual update for RY 2010 is based on the full forecasted estimated increase in the LTCH PPS market basket for RY 2010 of 2.5 percent, adjusted by the 0.25 percentage point reduction required by sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act, and an adjustment to account for the increase in case-mix in a prior period (FY 2007) resulting from changes in documentation and coding practices of −0.5 percent. In the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30969), under the authority of sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act, we proposed to amend § 412.523(c)(3)(vi) to specify that the standard Federal rate for the LTCH PPS rate year beginning October 1, 2009 and ending September 30, 2010, is the standard Federal rate for the previous rate year updated by 1.74 percent. Furthermore, in that same supplemental proposed rule, consistent with section 3401(p) of the Affordable Care Act, we also proposed to revise § 412.523(c)(3)(vi) to specify that, with respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate specified under § 412.523(c)(3)(v) updated by 2.0 percent (that is, a standard Federal rate of $39,896.65 (74 FR 44022)). We also noted that the provisions of the law that add sections 1886(m)(3) and (m)(4) of the Act are self-implementing, and in the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we proposed to incorporate existing law regarding the 0.25 percentage point reduction to the annual update to the standard Federal rate for RY 2010 (including the application of the revised standard Federal rate that reflects that 0.25 percentage point reduction in making payments for discharges on or after April 1, 2010) into the regulations at § 412.529(c)(3)(vi) to reflect this required policy change.

Comment: One commenter on the June 2, 2010 notice stated that the methodology CMS used to apply the market basket adjustment required by the Affordable Care Act appears to be a departure from what is intended by the statute and questions why CMS did not simply subtract the required 0.25 percentage point reduction for RY 2010 from the previously established RY 2010 update (implemented in the FY 2010 IPPS/RY 2010 LTCH PPS final rule). The commenter believed that the required market basket reduction should be implemented by subtraction and requested that CMS explain its method for implementing the required 0.25 percentage point reduction for RY 2010.

Response: We disagree with the commenter that our implementation of the required market basket reduction for RY 2010 required by the Affordable Care Act is inconsistent with the intent of that statutory provision. As we stated in the notice that implemented the required 0.25 percentage point reduction for RY 2010, "consistent with sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act, the market basket update under the LTCH PPS for RY 2010 is 2.25 percent (that is, the second quarter 2009 forecast estimate of the RY 2010 LTCH PPS market basket increase of 2.5 percent *minus the 0.25 percentage point* required by sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act.)" (emphasis added; 75 FR 31128). Thus, we implemented the statutorily required market basket reduction (0.25 percentage point for RY 2010) by subtraction from the full market basket update (2.5 percent) that was established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (2.5 percent minus 0.25 percentage point = 2.25 percent).

However, in addition to the full market basket update, in determining the update for the standard Federal rate for RY 2010, we applied an adjustment to account for the increase in case-mix due to changes in documentation and coding in a prior period that do not reflect increased severity of illness. Specifically, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43972), we established a −0.5 percent adjustment to account for the increase in case-mix due to changes in documentation and coding in a prior period (FY 2007) that do not reflect increased severity of illness. Therefore, consistent with our methodology for determining the update to the standard Federal rate for RY 2010 (74 FR 44022), in the June 2, 2010 notice (75 FR 31128), we established an update factor to the standard Federal rate for RY 2010 of 1.74 percent calculated as 1.0225 × (1 divided by 1.005) = 1.0174 or 1.74 percent. For the reasons explained above, we believe the determination of the 1.74 percent update for RY 2010 based on the market basket update of 2.25 percent (computed as the full RY 2010 market basket increase of 2.5 percent minus the 0.25 percentage point required by sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act) and an adjustment of −0.5 percent to account for the increase in case-mix due to changes in documentation and coding in a prior period that do not reflect increased severity of illness is

consistent with the provisions of the Affordable Care Act.

In this final rule, we are adopting as final the proposed changes to the update for RY 2010 to the standard Federal rate at § 412.523(c)(3)(vi) to reflect the provisions of the Affordable Care Act. Accordingly, under the authority of sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act, we are revising § 412.523(c)(3)(vi) to specify that the standard Federal rate for the LTCH PPS rate year beginning October 1, 2009 and ending September 30, 2010, is the standard Federal rate for the previous rate year updated by 1.74 percent. Furthermore, consistent with section 3401(p) of the Affordable Care Act, we also are revising § 412.523(c)(3)(vi) to specify that, with respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate in § 412.523(c)(3)(v) updated by 2.0 percent.

d. Market Basket Under the LTCH PPS for FY 2011

As discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), 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, as we stated in the FY 2011 IPPS/LTCH PPS proposed rule, 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.

As we also stated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), 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 reflects the cost structure of LTCHs. For the reasons explained above, in that same proposed rule, we proposed to continue to use the FY 2002-based RPL market basket under the LTCH PPS for FY 2011. We also stated that we are hopeful that progress can be made in the near future with respect to creating stand-alone market baskets for LTCHs, IRFs, and IPFs and, as a result, may propose to rebase the appropriate market basket(s) for subsequent updates in the future.

Comment: One commenter stated that there are sufficient LTCHs now to support the development of a separate LTCH market basket. The commenter stated that in order for the LTCH PPS to accurately reflect the costs of providing services in an LTCH, CMS should adopt a market basket that is limited to LTCH goods and services.

Response: As stated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), we continue to explore the possibility of implementing three separate, stand-alone market baskets for hospitals excluded from the IPPS, rather than use a single RPL market basket for IRFs, IPFs, and LTCHs. We addressed a similar comment in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43968) where we stated that while the number of LTCHs submitting cost report data has increased, we believe further research is required to determine the feasibility of developing stand-alone market baskets for LTCHs, IRFs, and IPFs. Furthermore, we stated that we will be exploring the viability and technical appropriateness of a stand-alone market basket. At this time, we are still conducting further research to assist us in understanding the reasons for the variations in costs and cost structure between freestanding and hospital based providers, specifically IRFs and 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 this final rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we are establishing the continued use of the FY 2002-based RPL market basket under the LTCH PPS for FY 2011. For the reasons explained above in this section, we continue to believe that the RPL market basket appropriately reflects the cost structure of LTCHs.

e. 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. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), 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 was 2.4 percent, as this was the best available data at that time. In addition, consistent with our historical practice of using market basket estimates based on the most recent available data, we proposed that if more recent data are available when we develop the final rule, we would use such data, if appropriate.

Section 1886(m)(3)(A)(ii) of the Act as added by section 3401(c) of the Affordable Care Act specifies that, for each of RYs 2010 through 2019, any annual update to the standard Federal rate shall be reduced by the other adjustment specified in new section 1886(m)(4) of the Act. Furthermore, section 1886(m)(3)(A)(i) of the Act specifies that, for rate year 2012 and each subsequent rate year, any annual update to the standard Federal rate shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

As discussed in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30969 through 30970), for FY 2011, section 1886(m)(4)(B) of the Act, as added and amended by sections 3401(c), 10319(b), and 1105(b) of the Affordable Care Act, requires a 0.50 percentage point reduction to the annual update to the standard Federal rate for rate year 2011. Therefore in that same supplemental proposed rule, we proposed a market basket update under the LTCH PPS for FY 2011 of 1.9 percent (that is, the most recent estimate of the LTCH PPS market basket update at that time of 2.4 percent minus the 0.50 percentage point required in section 1886(m)(4)(B) of the Act. Again, consistent with our historical practice of using market basket estimates based on the most recent available data, we proposed that if more recent data are available when we develop the final rule, we would use such data, if appropriate, in determining the final

market basket update under the LTCH PPS for FY 2011. (We note that in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30969 through 30970), we proposed to update the LTCH PPS standard Federal rate by −0.59 percent for FY 2011, which reflected the proposed market basket update of 1.9 percent (discussed above) and a proposed adjustment to account for the increase in case-mix in the prior periods that resulted from changes in documentation and coding practices rather than increases in patients' severity of illness (discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24045 through 24046)).

We did not receive any public comments on our proposed market basket update under the LTCH PPS for FY 2011 of 1.9 percent. However, we received a few comments that stated that the market basket update for FY 2011 should not be adjusted to account for the increase in case-mix in the prior periods that resulted from changes in documentation and coding practices rather than increases in patients' severity of illness. We summarize and respond to these comments below in section VII.C.3. of this preamble.

In this final rule, as proposed and 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 second quarter 2010 forecast, the FY 2011 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket is 2.5 percent.

As discussed above, for FY 2011, section 1886(m)(4)(B) of the Act as added and amended by sections 3401(c), 10319 and 1105(b) of the Affordable Care Act, requires a 0.50 percentage point reduction to the annual update to the standard Federal rate for rate year 2011. Therefore, in this final rule, we are establishing a market basket update under the LTCH PPS for FY 2011 of 2.0 percent (that is, the most recent estimate of the LTCH PPS market basket of 2.5 percent minus the 0.50 percentage point required in section 1886(m)(4)(B) of the Act. (We note that in section III.A. of the Addendum to this final rule, for FY 2011, we are establishing an update to the LTCH PPS standard Federal rate of −0.49 percent, based on the market basket update for FY 2011 of 2.0 percent (discussed above) and an adjustment of −2.5 percent to account for the increase in case-mix in the prior periods that resulted from changes in documentation and coding practices rather than increases in patient severity of illness (discussed below in section VII.C.3. of this preamble).)

f. Labor-Related Share Under the LTCH PPS for FY 2011

As discussed in section V.B. of the Addendum to this final rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS 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. In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), 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 proposed 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, consistent with our historical practice of using the best available data, in the FY 2011 IPPS/LTCH PPS proposed rule, we proposed 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 were the most recent available data at that time. Consistent with our historical practice of using the best data available, we also proposed 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.

As discussed in the FY 2011 IPPS/LTCH PPS proposed rule, the labor-related share for FY 2011 would continue to be determined as the sum of the 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. Using the best available data at that time and our proposed methodology, we proposed a labor-related share of 75.407 percent for use under the LTCH PPS in FY 2011. We did not receive any public comments on our proposed labor-related share for FY 2011. Therefore, we are adopting our proposed methodology for determining the labor-related share as final and applying it to the best available data consistent with our historical practice in this final rule.

In this final rule, as we proposed, for FY 2011 we continue to define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, labor-intensive services, and a labor-related portion of capital based on the FY 2002-based RPL market basket. Consistent with our historical practice of using the best available data, for this final rule, we are using IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the labor-related share under the LTCH PPS for FY 2011 that will be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data.

Based on IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2002-based RPL market based basket for FY 2011, which is currently the best available data, the sum of the relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) is 71.384 percent, as shown in the chart below. As stated in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24044), 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 is 8.450 percent of the FY 2002-based RPL market basket, we are taking 46 percent of 8.450 percent to determine the labor-related share of capital for FY 2011. The result is 3.887 percent, which we added to 71.384 percent for the operating cost amount to determine the total labor-related share for FY 2011. Accordingly, under the authority set forth in section

123 of the BBRA as amended by section 307(b) of the BIPA, we are establishing a labor-related share of 75.271 percent under the LTCH PPS for the FY 2011.

The chart below shows the FY 2011 relative importance labor-related share using the FY 2002-based RPL market basket.

FY 2011 LABOR-RELATED SHARE BASED ON THE FY 2002-BASED RPL MARKET BASKET

Cost category	FY 2011 relative importance (percent)
Wages and Salaries	52.449
Employee Benefits	13.971
Professional Fees	2.855
All Other Labor-Intensive Services	2.109
Subtotal	71.384
Labor-Related Share of Capital Costs (46 percent × 8.450)	3.887
Total Labor-Related Share	75.271

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

a. Background

Beginning in RY 2007, in updating the standard Federal rate for the LTCH PPS, we have accounted for increases in payments from a past period that were due to changes in 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 2010 IPPS/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 FY 2010 IPPS/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 FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed to apply a cumulative adjustment for the effect of 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/RY 2010 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 effect of documentation and coding increase that occurred in FY 2007. 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 effect 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24045 through 24046), we 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 the effect of 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).) Based on the results of this analysis, we estimated that the effect of documentation and coding changes that occurred in FYs 2008 and 2009 was 2.5 percent. (We refer readers to the discussion in the FY 2011 IPPS/LTCH PPS proposed rule (74 FR 24045 through 24046) for additional details on the methodology and results of the retrospective evaluation of the FY 2009 claims updated through December 2009.) We also noted in the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules that we applied our 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, in the FY 2011 IPPS/LTCH PPS proposed rule, we explained that 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 sought public comment on this proposal. We did not receive any public comments on the proposal to apply our established methodology for determining the cumulative effects of documentation and coding for FYs 2008 and 2009. Therefore, we are adopting this proposal as final in this final rule.

For this final rule, consistent with our historical practice and as we proposed, we updated our analysis using FY 2010 claims updated through March 2010 and the same methodology employed in the FY 2011 IPPS/LTCH PPS proposed rule. This analysis also resulted in an estimated effect of documentation and coding in FYs 2008 and 2009 of 2.5 percent. We received several comments on our proposed methodology for estimating the effect of documentation

and coding in FYs 2008 and 2009 and our proposal to apply an adjustment for the effect of documentation and coding in a prior period (FYs 2008 and 2009) that do not reflect an increase in severity of illness of −2.5 percent (discussed below), especially from national LTCH associations, hospital systems, and individual hospitals. MedPAC also commented on these proposals. A summary of these comments and our responses are presented below in the section VII.C.3.c. of this preamble.

c. FY 2011 Documentation and Coding Adjustment

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046), based on retrospective analysis of FY 2009 LTCH claims data (discussed above), we proposed to apply an adjustment for changes in documentation and coding in a prior period (FYs 2008 and 2009) that do not reflect an increase in severity of illness of −2.5 percent. Accordingly, we proposed to update the standard Federal rate for FY 2011 based on the most recent estimate of the market basket increase, including the required percentage point reduction and a proposed adjustment to account for changes in documentation and coding practices of −2.5 percent. We received the following public comments on that proposal:

Comment: MedPAC concurred with CMS' methodology used to estimate the documentation and coding effect for LTCH and CMS' proposal to reduce LTCH payment rates by 2.5 percent, noting that the implementation of MS–LTC–DRGs in 2008 gave LTCHs a financial incentive to improve documentation and coding to more fully account for each patient's severity of illness and that there was a need for "counterbalancing adjustments to LTCH payments to offset the effects of case-mix increases due to changes in documentation and coding practice."

Response: We appreciate MedPAC's independent validation and support of our methodology, and its support of our proposal to reduce LTCH payment rates by 2.5 percent to prevent overpayments under the LTCH PPS.

Comment: Most commenters questioned our proposed methodology for determining the magnitude of the effect of documentation and coding due to the adoption of the MS–LTC–DRGs. As commenters have argued in response to prior rulemaking, most of these commenters again asserted that our proposed methodology made assumptions about the cause of the case-mix increase that were unsupported and that failed to consider "other explanations" for those case-mix changes, in particular whether actual patient severity of illness (that is, "real" case-mix) has increased or whether the adoption of a more refined patient classification system (that is, the MS–LTC–DRGs) by its design reflects increased case-mix.

Response: We disagree that the methodology employed by our actuaries to determine the effect of documentation and coding due to the adoption of the MS–LTC–DRGs is based on unsupported assumptions. As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43971), overall case-mix change is predominately comprised of three factors: "real" case-mix change; a documentation and coding effect ("apparent" change); and a measurement effect. Because our proposed methodology uses the same year of claims data, it is not necessary to account for "real" case-mix-growth. This is because there can be no real case-mix growth measured if the same claims are used since the same set of patients (that is, the same claims data) is being used under the two GROUPERs classifications and relative weights.

We agree that the MS–LTC–DRGs were designed to better recognize severity of illness among patients and may reflect case-mix increase. However, consistent with the budget neutrality requirement that was established concurrent with the adoption of the MS–LTC–DRG patient classification system in FY 2008, the annual update to the classifications and weights should not increase or decrease aggregate LTCH PPS payments. In other words, these changes were intended to be done in a budget neutral manner. Therefore, to the extent that the adoption of the MS–LTC–DRGs themselves reflects a change in case-mix that results in an increase or decrease in aggregate LTCH PPS payments, it is appropriate to make an adjustment to account for such changes. In other words, a documentation and coding adjustment is now necessary because the changes in the classifications and weights associated with the adoption of the MS–LTC–DRGs should not increase or decrease the aggregate LTCH PPS payments.

Furthermore, as summarized above, in its public comments on our proposal, MedPAC concurred with our proposed methodology to estimate the documentation and coding effect for LTCH and independently verified our results that the effect is 2.5 percent. MedPAC also noted that the implementation of MS–LTC–DRGs in 2008 gave LTCHs a financial incentive to improve documentation and coding to more fully account for each patient's severity of illness.

Accordingly, we continue to find the methodology used by our actuaries and endorsed by MedPAC to determine the magnitude of the increase in case-mix due to the changes in documentation and coding in FYs 2008 and 2009 that do not reflect patient severity of illness to be the most appropriate methodology.

Comment: Most commenters opposed the proposed −2.5 percent adjustment to account for the increase in case-mix due to the effects of documentation and coding in FYs 2008 and 2009 that do not reflect severity of illness. As in prior rulemaking on this issue, most commenters again questioned the methodology used by our actuaries and endorsed by MedPAC to estimate LTCH case-mix increase due to the effects of documentation and coding that do not reflect increased severity of illness. Many of these comments were similar to or referenced the comment by NALTH, which in summary stated: "NALTH takes issue with the proposed adjustment of −2.5 percent to the update factor for changes in documentation and coding practices that CMS claims occurred between FYs 2007 through 2009. * * * In summary, we have made findings that CMS' methodology does not result in an accurate identification of 'apparent' as differentiated from 'real' case-mix severity change from FY 2007 to FY 2009."

NALTH asserted that this conclusion is supported by a number of factors. First, NALTH stated that changes in the law have led to changes in the distribution of patients admitted to LTCHs between FY 2007 and FY 2009. Second, NALTH asserted that, under our methodology, a finding of no increase in case-mix due to documentation and coding changes "could only occur by pure chance" and that the adoption of the "decompressed" MS–LTC–DRG GROUPER results in a more accurate measurement of severity for high acuity patients. Third, NALTH indicated that changes between primary and secondary diagnosis codes led to a decrease, not increase, in case-mix. Fourth, NALTH used a regression analysis to compare the actual and predicted prevalence of diagnoses and procedure codes for FY 2009 LTCH discharges. Fifth, NALTH cited standards of ethical coding applied by coding professionals that prevent changing a primary diagnosis to a secondary diagnosis to maximize reimbursement. Sixth, NALTH cited "resequencing guidelines" that have been in effect since 2005 and the SSO policy, under which NALTH believes

that 50 percent to 60 percent of all LTCH cases are typically paid less than a full MS–LTC–DRG payment, as reasons that there is no evidence to conclude that documentation and coding practices contribute significantly to case-mix changes. Lastly, NALTH stated that approximately 60 percent of the change in FY 2009 GROUPER case-mix from FY 2007 to FY 2009 is due to a redistribution in case-mix from FY 2007 through FY 2009 and approximately 25 percent of the case-mix growth is due to an increase in the comorbidities of certain high volume ICD–9–CM codes from FY 2007 through FY 2009. NALTH stated that the remaining 15 percent could be due to an "apparent" increase in case-mix and, therefore, believed that, at most, the proposed coding adjustment should be −0.8 percent.

Response: Both the adoption of the severity-adjusted MS–LTC–DRGs as the patient classification system under the LTCH PPS and the establishment of the budget neutrality requirement for the annual update to the MS–LTC–DRG classifications and relative weights were effective beginning in FY 2008. The changes in the classifications and relative weights associated with FY 2008 and FY 2009 MS–LTC–DRGs were established to improve the accuracy of the distribution of payments among LTCH patients, not to increase or decrease aggregate LTCH PPS payments. In other words, these changes were intended to be done in a budget neutral manner. A retrospective review of LTCH claims data allows a determination to be made as to the extent to which these changes resulted in an increase or decrease in aggregate LTCH PPS payments, so an offsetting budget neutrality adjustment can be made. Specifically, a retrospective analysis of the LTCH claims data can examine the change in the average case-mix under the old (for example, FY 2007) and new (for example, FY 2009) classifications and weights. As stated above in our discussion of the documentation and classification adjustment for IPPS hospitals in section II.D. of this preamble and also in prior rulemaking (74 FR 43771 and 43971), overall case-mix change is predominately comprised of three factors: "real" case-mix change; a documentation and coding effect ("apparent" change); and a measurement effect. Because year-to-year changes in real case-mix are not intended to be budget neutral, this must be accounted for in the analysis of case-mix change. The simplest and most straightforward way to account for changes in real case-mix is to directly remove them from the calculation. This is exactly what the proposed methodology employed by our actuaries and endorsed by MedPAC does. Our actuaries compare the case-mix calculated using the same FY 2009 cases grouped using the FY 2009 MS–LTC–DRG classifications and relative weights and the FY 2007 LTC–DRG classifications and relative weights to determine the combined effect of documentation and coding changes and measurement. An adjustment is then made to net out the measurement effect. Therefore, differences in case-mix calculated using the FY 2007 and FY 2009 classifications and relative weights on the FY 2009 data are not affected by real case-mix change, by definition, because the same set of patients (that is, the same claims data) is being used under the two GROUPERs classifications and relative weights. This simple fact refutes the NALTH assertion that our methodology "does not result in an accurate identification of 'apparent' as differentiated from 'real' case mix severity change from FY 2007 to FY 2009."

Furthermore, none of the supporting factors listed by NALTH refute our methodology. The first factor, changes in the distribution of patients admitted to LTCHs between FY 2007 and FY 2009, and the portion of the seventh factor involving increases in patient acuity, would influence the change in real case-mix. As explained above, our methodology directly removes the changes in real case-mix from the determination of the increase in case-mix due to the effects of documentation and coding in FYs 2008 and 2009 that do not reflect increased severity of illness.

A number of the remaining factors (specifically, factors two, three, four and seven) listed by NALTH involve differences in the distribution of cases between FY 2007 and FY 2009. Again, the purpose of the proposed documentation and coding adjustment is to ensure that the changes in the classification and relative weights associated with FY 2008 and FY 2009 MS–LTC–DRGs do not increase or decrease the aggregate LTCH PPS payments. We agree that there is a difference between the distribution of cases in FY 2007 and the distribution of cases in FY 2009. However, this is not a refutation of our methodology. In fact, it supports the necessity of our proposed documentation and coding adjustment. Had we known the actual distribution of FY 2009 cases when we initially determined the FY 2009 budget neutral update to the MS–LTC–DRG classifications and relative weights back in 2008, we would have used this information at that time and no further adjustment would now be necessary to ensure that the FY 2009 update did not increase or decrease the aggregate LTCH PPS payments. As this information was unknown in 2008, we used the most recent full year of LTCH claims data available to us to update the MS–LTC–DRG classifications and relative weights for FY 2009 in a budget neutrality manner. A finding that the actual distribution of cases differs from the distribution used in determining the initial budget neutral relative weights is precisely the reason that an additional adjustment is now necessary: we do not want changes in the classifications and weights associated with FY 2008 and FY 2009 MS–LTC–DRGs to increase or decrease the aggregate LTCH PPS payments.

In response to the assertion that the standards of ethical coding applied by coding professionals prevent changing a primary diagnosis to a secondary diagnosis to maximize reimbursement, we have never asserted that any party acted inappropriately, unethically, or otherwise in bad faith by employing documentation and coding improvement practices associated with the adoption the MS–LTC–DRG system. Under the previous DRG definitions, it was possible for high-severity cases to be paid the same as cases with lower severity if they grouped to the same DRG. The MS–LTC–DRGs were introduced as part of the effort to ensure that the relative Medicare payment rates that hospitals received more reasonably matched the resources hospitals expended in furnishing care, and CMS encouraged hospitals to code as accurately as possible with that goal in mind. However, it is our finding that the systematic effect of changing documentation and coding practices has led to an increase in LTCHs' overall case-mix that does not reflect a commensurate increase in LTCH patient severity of illness, and as we discuss in greater detail below, it is appropriate to adjust the LTCH PPS payment rates to account for the increased level of LTCH PPS payments due to such documentation and coding.

The sixth factor noted by NALTH, which contends that "resequencing guidelines" that have been effective since April 2005 and the SSO policy may result in a decrease in payment upon the adoption of the MS–LTC–DRGs, is not evidence that changes in documentation and coding practices do not contribute significantly to case-mix changes. We agree that, in some cases, the ICD–9–CM coding guidelines may result in a case being grouped to a MS–LTC–DRG with a lower weight

compared to an alternative sequencing of ICD–9–CM codes for that case and, therefore, will receive a lower payment. However, in other instances, the ICD–9–CM coding guidelines may result in a case being grouped to a MS–LTC–DRG with a higher weight and, therefore, will receive a higher payment. This fact demonstrates that documentation and coding practices have an impact on case-mix and, therefore, also on aggregate LTCH PPS payments. As we have discussed above, we believe it is appropriate to make an adjustment to the LTCH PPS payment rates to account for any changes in aggregate LTCH PPS payments due to such documentation and coding under the MS–LTC–DRGs as compared to the effect of the CMS LTC–DRGs (that were in effect prior to the adoption of the MS–LTC–DRGs) on LTCHs' case-mix.

Similarly, with regard to the SSO policy, we agree that when a case is grouped to a higher weighted MS–LTC–DRG for FY 2009 (relative to the weight of the FY 2007 LTC–DRG to which it groups), it may become a SSO case (and receive a payment that is less than the full LTC–DRG payment). This is the case because the average length of stay for the "higher weighted" FY 2009 MS LTC–DRG is based on the data for higher severity, more resource intensive cases, which generally have a relatively longer length of stay. However, it is also true that the cases in a "lower weighted" FY 2009 MS–LTC–DRGs will generally have a relatively shorter length of stay under the MS–LTC–DRGs, as compared to the FY 2007 LTC–DRGs, because the lower weighted MS–LTC–DRG will require less resources. Therefore, a case that would have been a SSO under the FY 2007 LTC–DRG classifications may no longer be a SSO case under the FY 2009 MS–LTC–DRGs (and is paid a full MS–LTC–DRG payment).

As discussed above, under our budget neutrality requirement for the annual update to the MS–LTC–DRGs, we believe it is appropriate to make an adjustment to the LTCH PPS payment rates to account for any changes in aggregate LTCH PPS payments as a result of the transition from the LTC–DRGs to the MS–LTC–DRGs. Furthermore, we disagree with the commenter that 50 percent to 60 percent of all LTCH cases are typically paid *less* than a full MS–LTC–DRG payment under the SSO policy. Historically, approximately 30 to 35 percent of all LTCH cases are typically paid under the SSO policy. Specifically, an analysis of FY 2009 LTCH claims data shows that approximately 31 percent of all LTCH cases were paid under the SSO policy (and received less than a full MS–LTC–DRG payment). Moreover, of those cases paid under the SSO policy, the payment for approximately 40 percent of those SSO cases is determined in part based on the MS–LTC–DRG relative weight for the case. Thus, the LTCH PPS payment to the vast majority of LTCH cases is determined based on the MS–LTC–DRG relative weight. Therefore, documentation and coding under the FY 2009 MS–LTC–DRGs that results in the aggregate grouping to a higher weighted MS–LTC–DRG do affect aggregate LTCH PPS payments. To the extent this occurs, as discussed in greater detail above, it is appropriate to make an adjustment to the LTCH PPS payment rates to account for any changes in aggregate LTCH PPS payments.

After consideration of these public comments, we continue to find the methodology used by our actuaries and endorsed by MedPAC to determine the magnitude of the increase in case-mix due to the effects of documentation and coding resulting from the adoption of the MS–LTC–DRGs in FYs 2008 and 2009 that do not reflect increased severity of illness to be the most appropriate methodology because it directly removes real changes in case-mix from the calculation. The distributional analyses submitted by NALTH also indicate that the classifications and relative weights associated with FY 2008 and FY 2009 MS–LTC–DRGs increased aggregate LTCH PPS payments and support the need for a documentation and coding adjustment.

Comment: In addition to challenging the proposed methodology for determining the proposed −2.5 percent documentation and coding adjustment, some commenters argued, as they have in response to past rulemaking, that there is no statutory authority to apply the proposed −2.5 percent documentation and coding adjustment. Again, these commenters stated that Public Law 110–90 contains explicit authority to make a documentation and coding adjustment to IPPS hospitals, but does not extend that authority to hospitals paid under the LTCH PPS. One commenter argues that the Secretary lacks the authority to make a documentation and coding adjustment under the LTCH PPS based on the statutory construct, wherein the LTCH PPS is explicitly omitted from the requirements of Public Law 110–90. The commenter also asserted that the Secretary's "broad authority" under section 123 of the BBRA, as amended by section 307(b) of the BIPA, is "misplaced," given such a statutory construct.

Response: We continue to disagree with commenters that the Secretary's broad authority under section 123 of the BBRA, as amended by section 307(b) of the BIPA, "to provide for appropriate adjustments," including updates, is misplaced and cannot be applied in this instance. We have discussed the basis for applying an adjustment for the effects of documentation and coding that do not reflect increased severity of illness in prior rules (most recently in the FY 2010 IPPS/RY 2010 LTCH final rule (74 FR 43970)) and do not agree that the omission of the applicability of the requirements of Pub. L. 110–90 to the LTCH PPS limits our authority under section 123 of the BBRA, as amended by section 307(b) of the BIPA, to make such an adjustment.

Comment: Some commenters believed that, in proposing a −2.5 percent adjustment to account for "apparent" case-mix increases from prior years, CMS is not appropriately applying the market basket update, whose purpose is to account for the expected increase in the prices of goods and services for the upcoming year. The commenters stated that CMS provides no data that prices in FY 2011 will increase less than the full market basket estimate, nor does CMS explain how case-mix changes relate to the changes in the price of inputs measured by the market basket. A few commenters also argued that there is no basis in the existing regulations to adjust for changes in case-mix in determining an appropriate market basket increase. The commenters stated that CMS should update the standard Federal rate by "the full market basket update" for FY 2011.

Response: In the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046), we proposed to update to the standard Federal rate for FY 2011 based on the most recent estimate of the full market basket increase at that time and based on a proposed adjustment to account for changes in documentation and coding practices. As noted above, due to the timing of the passage of the Affordable Care Act, we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, and the proposed policies and payment rates in that proposed rule did not reflect the new legislation. Consequently, in the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30968 through 30970), we revised our proposed update to the standard Federal rate for FY 2011, consistent with the provisions of the Affordable Care Act, which added sections 1886(m)(3)(A)(ii) and 1886(m)(4)(B) to the Act that require a

0.50 percentage point reduction to the annual update for rate year 2011.

Consistent with this requirement, in that same supplemental proposed rule, we proposed an update to the standard Federal rate for FY 2011 based on the most recent estimate of the full market basket increase at that time minus the 0.50 percentage point required in section 1886(m)(4)(B) of the Act and based on a proposed adjustment to account for changes in documentation and coding practices. Therefore, we disagree with the commenters that we did not appropriately apply the market basket update because our proposed update did include the full market basket increase to account for the expected increase in prices for FY 2011, adjusted by the statutorily required 0.50 percentage point reduction. However, the full market basket increase (including the required statutory reduction) is not the only factor used in determining our proposed update for FY 2011. As discussed above, the Secretary has broad authority under the statute to determine appropriate updates under the LTCH PPS, and we believe it is appropriate that the update to the standard Federal rate reflect an adjustment to account for changes in case-mix due to the effects of documentation and coding that do not reflect increased patient severity of illness and costs ("apparent" case-mix changes).

The component of our proposed update to the standard Federal rate for FY 2011 to account for "apparent" case-mix changes is not intended to adjust for the expected changes in the price of inputs for the upcoming year, FY 2011 (as measured by the market basket), but to prospectively adjust the rate so that the increased level of payments that occurred due to the effects of documentation and coding that do not reflect increased patient severity of illness do not continue into future years. As MedPAC stated in its public comment, LTCH payment rates should be reduced by the proposed adjustment for the effects of documentation and coding in FYs 2008 and 2009 that do not reflect increased severity of illness "to prevent further overpayments."

We disagree that prior annual updates to the LTCH PPS have addressed the effects of documentation and coding practices in FYs 2008 and 2009. Although we have made adjustments for the effects of documentation and coding practices that do not reflect increased patient severity of illness in establishing an update to the standard Federal rate for the past 4 years (RYs 2007 through 2010), those adjustments were based on LTCH claims data from FYs 2004 through 2007, respectively. To date, we have never based any adjustment based on the change in case-mix identified in FYs 2008 or FY 2009 claims data. Specifically, in the FY 2008 and FY 2009 final rules, we explained that we believe that the adoption of the MS–LTC–DRGs would create a risk of increased aggregate levels of payment as a result of changes in documentation and coding practices. However, we did not establish any prospective adjustment to account for the effect of documentation and coding for FY 2008 or FY 2009 resulting from the adoption of the MS–LTC–DRG system because, at the time, we had not been able to determine an appropriate adjustment factor for LTCHs and because we had an established mechanism to adjust LTCH PPS payments to account for the effects of documentation and coding practices in a prior period based on actual LTCH data. Instead, we indicated that we would continue to monitor the LTCH payment system, and should we find any "apparent" case-mix increase due to the adoption of the MS–LTC–DRG classification system, we would propose appropriate adjustments to account for that case-mix increase that is not due to increased severity of illness. We also discussed our intended future evaluation of LTCH claims data and resulting case-mix growth from the implementation of the MS–LTC–DRG system, similar to the evaluation that we intended for the MS–DRG system under the IPPS, and stated that the analysis, findings, and any resulting proposals to adjust payments to offset the estimated amount of increase or decrease in aggregate payments that occurred in FY 2008 and FY 2009 for LTCHs as a result of the effect of documentation and coding, will be discussed in future years' proposed rules, which would be open for public comment. ((72 FR 47297 through 47299) and (73 FR 26809))

With respect to the comment that there is no basis in the existing regulations to adjust for changes in case-mix in determining an appropriate market basket increase, as we discuss above, we are not accounting for case-mix changes in determining an appropriate market basket increase. Rather, as explained above, our proposed update to the standard Federal rate for FY 2011 is based on the full market increase (including the required statutory reduction) and a separate component to adjust for the effect of case-mix changes in a prior period (FYs 2008 and 2009). Furthermore, we point out that the existing regulations in 42 CFR part 412, subpart 0 (the subpart governing the LTCH PPS) do not address future updates to the standard Federal rate, including the update for FY 2011.

Comment: Many of the commenters expressed concern that many of the proposals affecting the LTCH PPS payment rates for FY 2011, including the proposed decrease to the standard Federal rate and the proposed increase to the fixed-loss amount, violates the premise that the Medicare program will adequately reimburse LTCHs for the costs of treating Medicare beneficiaries and will result in payments that are below the costs incurred for treating these patients. The commenters contended that CMS did not consider all of its payment rate and policy changes in developing its proposals for FY 2011, especially the impact of the proposed increase in the high-cost outlier threshold, nor did CMS consider the combined impact of the proposed −2.5 percent documentation and coding adjustment and the reductions to the market basket update mandated by the Affordable Care Act.

Response: We understand the commenters' concern regarding the possible financial impact that may be caused by the proposed changes to the LTCH payment rates and factors for FY 2011. However, we disagree that we did not consider the overall impact of all proposed policy changes in developing our proposals for FY 2011 under the LTCH PPS. As we discussed in greater detail above in this preamble and in section V. of the Addendum of this final rule, we believe that the changes we proposed (and are finalizing) to the payment rates and factors for FY 2011 will result in an appropriate level of payments under the LTCH PPS. Specifically, with regard to the update to the standard Federal rate, which includes the reductions to the market basket update mandated by the Affordable Care Act (discussed in V. of the Addendum to this final rule), we agree with MedPAC that it is appropriate to focus on minimizing the accumulation of overpayments resulting from the effects of documentation and coding practices that do not reflect increased severity of illness (and costs) and should not further delay making the −2.5 percent adjustment to account for changes in documentation and coding practices in FYs 2008 and 2009 that do not reflect patient severity of illness. With regard to the increase to the high-cost outlier fixed-loss amount, as discussed in section V. C. of the Addendum of this final rule, based on the latest available data and payment rate changes we are establishing in this final rule, it is necessary to increase the fixed-loss amount for FY 2011 in order

to maintain the regulatory requirement that estimated high-cost outlier payments would be equal to 8 percent of estimated aggregate LTCH PPS payments.

Comment: Some commenters contended that the proposed −2.5 percent adjustment to account for the increase in case-mix due to the effects of documentation and coding practices that do not reflect increased severity of illness is "punitive," "excessive" and "unprecedented," stating that "the size, scope and timing of the proposed adjustment will have a severe impact on LTCHs." The commenters pointed out that CMS has never imposed an adjustment for the effect of documentation and coding practices that reduced the standard Federal rate to a level that falls below the rate of the prior year. The commenters stated further that CMS has never implemented a single adjustment based on multiple years of data, and asserted that adopting a reduction to the rates in a single fiscal year to reflect changes in case-mix that occurred over a 2-year period will have a significant financial impact on LTCHs. Although disagreeing that the proposed −2.5 percent adjustment to account for the increase case-mix due to the effects of documentation and coding practices that do not reflect increased severity of illness is warranted, the commenters recommended that, to mitigate the financial impact, CMS maintain the RY 2010 standard Federal rate or phase-in the proposed 2.5 percent reduction over a 3-year period.

Response: We understand the commenters' concern regarding the possible financial impact that may be caused by the proposed changes to the LTCH payment rates and factors for FY 2011. However, we disagree that we did not consider the overall impact of all proposed policy changes in developing our proposals for FY 2011 under the LTCH PPS. As we discussed in the regulatory impact analysis of the June 2, 2010 supplemental proposed rule, which reflected the provisions of the Affordable Care Act as well as other proposed rate and policy, we believe that the changes we proposed to the payment rates and factors for FY 2011 will result in an appropriate level of payments under the LTCH PPS. In that impact analysis, we projected an average 0.3 percent increase in aggregate LTCH PPS payments in FY 2011 as compared to RY 2010. In this final rule, we projected an average 0.5 percent increase in aggregate LTCH PPS payments in FY 2011, as compared to RY 2010.

It is true that we never implemented an adjustment for the effect of documentation and coding practices that reduced the standard Federal rate to a level below the rate that is currently in effect. It is also true that we previously have not implemented a single adjustment based on multiple years of data. However, as we have discussed in great detail in this section, we believe that documentation and coding adjustments to LTCH payments is necessary to offset the effects of case-mix increases due to documentation and coding practices under the MS–LTC–DRGs. We have consistently stated since the adoption of the MS–LTC–DRGs beginning in FY 2008 that we believe that the adoption of the MS–LTC–DRGs would create a risk of increased aggregate levels of payment as a result of the effects of documentation and coding practices. However, we did not establish any prospective adjustment to account for improved coding practices for FY 2008 or FY 2009 resulting from the adoption of the MS–LTC–DRG system because, at the time, we had not been able to determine an appropriate adjustment factor for LTCHs and because we had an established mechanism to adjust LTCH PPS payments to account for the effects in documentation and coding practices in a prior period based on actual LTCH data. Furthermore, as stated above, we agree with MedPAC that it is appropriate to focus on minimizing the accumulation of overpayments resulting from the effects of documentation and coding practices that do not reflect increased severity of illness (and costs) and should not further delay making the −2.5 percent adjustment to account for the effects of documentation and coding practices in FYs 2008 and 2009 that do not reflect severity of illness. Therefore, we are not adopting the commenters' suggestion to limit the adjustment so that the standard Federal rate remains at its current level or to phase-in the adjustment over more than one year. Accordingly, for the reasons discussed above, in this final rule, we are finalizing our proposal to apply a −2.5 percent adjustment to account for the effect of documentation and coding practices that do not reflect an increase in severity of illness due to the adoption of the MS–LTC–DRGs.

Therefore, in this final rule, under the Secretary's broad authority under section 123 of the BBRA, as amended by section 307(b) of the BIPA, to provide for appropriate adjustments, including updates, we are applying an adjustment for the effect of documentation and coding in a prior period (FYs 2008 and 2009) that do not reflect an increase in patient severity of illness of −2.5 percent. Accordingly, as discussed in section V. of the Addendum to this final rule, the update to the standard Federal rate for FY 2011 is −0.49 percent, which is based on the most recent estimate of the market basket increase, including the required percentage point reduction, of 2.0 percent and an adjustment to account for the effect of documentation and coding practices of −2.5 percent.

D. Change in Terminology From "Rate Year" to "Fiscal Year"

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046), we made several proposals that were designed to promote clarity regarding the changes that have been made to the schedule and terminology associated with the annual update for the LTCH standard Federal payment rates and the MS–LTC–DRG relative weights as well as the publication cycle for rulemaking for the LTCH PPS. A historical review of these changes is as follows:

- Initially, the standard Federal rates and the LTC–DRG classification and relative weights were established on a Federal Fiscal year (FY) cycle of October 1 through September, beginning October 1, 2002 (FY 2003).
- In the June 6, 2003 **Federal Register** (68 FR 34125), the LTCH PPS final rule changed the annual update of the standard Federal rate to a July 1 to June 30 cycle (the LTCH PPS rate year (RY)) while it continued to provide for an update of the LTC–DRG classification and relative weights on the FY schedule, effective from October 1 through September 30 in conformity with the IPPS.
- 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 weights for LTCHs so that the updates to the rates and factors have an October 1 effective date and occur on the same schedule and appear in the same **Federal Register** document. 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046 and 24047), we proposed to change the terminology used under the LTCH PPS with respect to the annual update to the standard

Federal rate and the MS–LTC–DRG relative weight recalibration cycle. Specifically, we proposed to change from using the term "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. Because the annual updates to both the LTCH PPS standard Federal rate (and associated factors) and the MS–LTC–DRG classifications and relative weights now occur at the same time as the annual updates under the IPPS, we believe this change eliminates any possible confusion that may be caused by continuing to identify the LTCH update cycle as a "rate year." Therefore, we proposed to use the term "fiscal year" when referring to the annual updates for the LTCH standard Federal payment rates and the MS–LTC–DRG relative weights as well as to the publication cycle for rulemaking for the LTCH PPS. We proposed to add a definition of "long-term care hospital prospective payment system fiscal year" at § 412.503 (75 FR 24058). We also proposed to revise our definition of "long-term care hospital prospective payment system rate year" in the regulations at § 412.503 to reflect that such term does not apply to time periods after September 30, 2010 (75 FR 24046 and 24058).

For a detailed description of our rationale regarding the above-described proposed changes, we refer the reader to the discussion in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046 and 24047).

In addition, we proposed 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. It is our intent that this 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 refer readers to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046) for a discussion of our rationale for this change. Also, as a conforming change, we proposed 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 change, which would reference the proposed new definition of the long-term care hospital prospective payment system payment year period at § 412.503, 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 changes present a straightforward way to provide additional clarity to our regulations in a circumstance that reflects changes in terminology but does not entail any change to the high-cost outlier policy.

We received several comments on this proposed clarification and revision of terminology, all of them strongly in favor of the proposed changes. Therefore, for the reasons set forth in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24046 through 24047) and in light of the public's support for our proposals, we are adopting as final without modification the proposed change in terminology from LTCH PPS "rate year" to LTCH PPS "fiscal year" beginning October 1, 2010 (FY 2011) and the proposed changes to § 412.503 with the addition of the definition of "long-term care hospital prospective payment system fiscal year" and the modification of the definition of "long-term care hospital prospective payment system rate year." We also are finalizing the addition of the term "long-term care hospital prospective payment system payment year" at § 412.503 and the conforming regulation text changes at § 412.525(a)(1) and (a)(2) to capture this new term.

E. Finalization of Interim Final Rule With Comment Period Implementing Section 4302 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) Relating to Payments to LTCHs and LTCH Satellite Facilities

1. Background

On August 27, 2009, we published in the **Federal Register** (74 FR 43990 through 43992), an interim final rule with comment period to implement certain provisions of section 4302 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5). Section 4302 of the ARRA amended several provisions of section 114 of the MMSEA relating to LTCHs. Specifically, section 4302(a) amended sections 114(c)(1) and (c)(2) of the MMSEA, and section 4302(b) amended section 114(d)(3)(A) of the MMSEA. In both cases, these ARRA provisions were to be effective and applicable as if the amendments had been included in the MMSEA. (The enactment of the Affordable Care Act amended certain provisions of the MMSEA which had been amended by the ARRA.) Below we briefly review the amendments made to sections 114(c)(1) and (c)(2) and section 114(d) of the MMSEA by section 4302(a) and (b), respectively, of the ARRA, respond to the one public comment that we received on the August 27, 2009 interim final rule with comment period, and finalize the policies as described below. (We note that the timeframes in these provisions were subsequently amended by the provisions of the Affordable Care Act as discussed below in section VII.F. of this preamble.)

2. Amendments Relating to Payment Adjustment to LTCHs and LTCH Satellite Facilities Made by Section 4302 of the ARRA

Section 114(c)(1)(A) and (B) of the MMSEA established a 3-year delay, for cost reporting periods beginning on or after December 29, 2007, for freestanding LTCHs (defined at § 412.23(e)(5)) and "grandfathered" long-term care hospitals-within-hospitals (HwHs), from the application of the percentage threshold payment adjustment established under § 412.536 or § 412.534, respectively, or any similar provision. Section 4302(a)(1) of the ARRA amended the provisions of sections 114(c)(1)(A) and (B) of the MMSEA as follows:

First, under section 4302(a)(1)(A) of the ARRA, the heading of section 114(c)(1) is changed to "Delay in Application of 25 Percent Patient Threshold Payment Adjustment" from the original "No Application of 25 Percent Patient Threshold Payment Adjustment to Freestanding and Grandfathered LTCHs."

Second, under section 4302(a)(1)(B) of the ARRA, the effective date of the delay in application of the 25-percent patient threshold payment adjustment found in section 114(c)(1) of the MMSEA is changed from the date of enactment of the MMSEA (that is, December 29, 2007) to July 1, 2007. As a result, for a "grandfathered" long-term care HwH or a "freestanding" LTCH with a cost reporting period beginning before December 29, 2007, the applicable payment adjustments at § 412.534(h) and § 412.536 would be delayed 3 years. This is the case because our regulations at § 412.534(h), with respect to "grandfathered" LTCHs, and § 412.536 with respect to all LTCHs, were to be effective beginning with cost reporting periods beginning on or after July 1, 2007. Therefore, the amendment made by section 4302(a)(1)(B) of the ARRA to section 114(c)(1) of the MMSEA results

in a uniform application of the statutory 3-year relief from the 25 percentage threshold payment adjustment.

Third, section 4302(a)(1)(C) of the ARRA added, for 3 years, a third category of LTCHs that will not be subject to §§ 412.534 and 412.536, or any similar provisions of the regulations for a 3-year period for cost reporting periods beginning on or after July 1, 2007. Specifically, section 4302(a)(1)(C) of the ARRA extended the 3-year exemption from the percentage threshold payment adjustments at §§ 412.534 and 412.536 to include "* * * a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location * * *." Therefore, no percentage threshold (and therefore, no payment adjustment) will be applied for patients discharged from an acute care hospital who are admitted to a LTCH or LTCH satellite facility that is co-located with an entity that is a provider-based, off-campus location of an acute care hospital (as set forth in our regulations at § 413.65) as long as there are no inpatient acute care hospital services payable under section 1886(d) of the Act offered at that off-campus location. For example, this would apply to a situation where an acute care hospital, that Medicare pays under the IPPS, is located on the main campus of a multicampus entity and, on a second campus of that acute care hospital, the LTCH shares a building with an IRF unit or an outpatient clinic that is provider-based to the acute care hospital as long as there are no services payable under the IPPS hospital provided at that second campus.

Section 114(c)(2) of the MMSEA provided, for a 3-year period, increases in the percentage thresholds ("payment adjustments") established under § 412.534 for "applicable" LTCHs or satellite facilities for cost reporting periods beginning on or after December 29, 2007. Specifically, if the threshold percentage would have been 25 percent, for 3 years it will increase to 50 percent; and if the threshold would have been 50 percent prior to the enactment of the MMSEA, it will increase to 75 percent. The term "applicable" was defined as "* * * a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42 of the Code of Federal Regulations." The revisions made by section 114(c)(2) of the MMSEA were limited to a hospital or a satellite subject to the transition rules at § 412.534(g) of the regulations. However, because "grandfathered" LTCH satellite facilities are subject to the transition at § 412.534(h) of the regulations, not at § 412.534(g), the percentage increase resulting from the application of section 114(c)(2) did not apply to them (73 FR 29703).

Section 4302(a)(2)(A) of the ARRA modified the definition of "applicable long-term care hospital or satellite facility." This provision amended section 114(c)(2)(B)(ii) of the MMSEA by specifying that those "grandfathered satellites" described in § 412.22(h)(3)(i) of the regulations were to be included in the definition. (Under § 412.22(h)(3)(i), "grandfathered" satellites were exempted from compliance with the "separateness and control" rules specified in § 412.22(h) if they had been structured as a satellite facility on or before September 30, 1999.) However, we note that "grandfathered satellites" under § 412.22(h)(3) continue to be subject to the applicable percentage thresholds outlined in § 412.536 for patients admitted from any individual hospital with which they were not co-located because there were no exceptions for such entities for purposes of payment as provided in § 412.536. Section 4302(a)(1)(C) of the ARRA provided that grandfathered satellite facilities under § 412.22(h)(3) will not be subject to §§ 412.534 and 412.536, or any similar provision of the regulations, for a 3-year period for cost reporting periods beginning on or after July 1, 2007. Specifically, under section 4302(a)(1)(C) of the ARRA that amended section 114(c)(1) of the MMSEA, no percentage threshold (and, therefore, no payment adjustment) will be applied for patients discharged from an acute care hospital who are admitted to a LTCH or LTCH satellite facility that, as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of an acute care hospital (as set forth in the regulations at § 413.65) as long as there are no inpatient acute care hospital services payable under section 1886(d) of the Act provided at that off-campus location.

Section 114(c)(2)(C) of the MMSEA applied the 3-year increase in the percentage thresholds at § 412.534 of the regulations for cost reporting periods beginning on or after the date of enactment of the MMSEA (December 29, 2007). Section 4302(a)(2)(B) of the ARRA revised the effective date of the MMSEA provisions to cost reporting periods beginning on or after October 1, 2007, for LTCHs and LTCH satellite facilities that were subject to the transition rules under § 412.534(g) and also established the effective date as cost reporting periods beginning on or after July 1, 2007, "* * * in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42 of the Code of Federal Regulations." (Different dates are applicable because the effective date for the 25 percent threshold payment adjustment policy for LTCHs and LTCH satellite facilities governed under § 412.534(g) was October 1, 2005, while the percent threshold for "grandfathered" LTCH satellite facilities policy was effective for cost reporting periods beginning on or after July 1, 2007.)

The result of this modification in the effective date of the 3-year increase in the percentage threshold for "applicable" LTCHs and LTCH satellite facilities (now including "grandfathered satellites") is that LTCHs and LTCH satellite facilities will not have the fully phased-in 25 percentage threshold payment adjustment applied for cost reporting periods beginning on or after October 1, 2007, and "grandfathered" satellite facilities will not be subject to the transition to the 25 percentage threshold for cost reporting periods beginning on or after July 1, 2007.

To implement the provisions of section 4302 of the ARRA, in the August 27, 2009 interim final rule with comment period, we revised the regulations at §§ 412.534 and 412.536 to reflect the statutory revisions described above.

Comment: One commenter stated that CMS had failed to specify that a "grandfathered" LTCH satellite facility that met the description of the third category of LTCHs and LTCH satellite facilities included in the amendment to section 114(c)(1) of the MMSEA by section 4302(a)(1)(C) of the ARRA (that is, "* * * a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location") was also exempt from compliance with the 25-percent policy for 3 years.

Response: We agree all those LTCH satellite facilities described above are exempt from the 25-percent policy at § 412.536 for 3 years.

In this final rule, we are finalizing the provisions of the August 27, 2009 interim final rule with comment period which revised the regulations at §§ 412.534 and 412.536 to reflect the ARRA statutory revisions.

3. Amendment to the Moratorium on the Increase in Number of Beds in Existing LTCHs or LTCH Satellite Facilities Made by Section 4302 of the ARRA

Section 114(d) of the MMSEA provided a 3-year moratorium on any increase in the number of hospital beds in existing LTCHs and LTCH satellite facilities. (The definition of an existing LTCH and LTCH satellite facility for purposes of this policy is codified at § 412.23(e)(7)(i).) Section 114(d) of the MMSEA included an exception to the moratorium on the increase in hospital beds in existing LTCHs and LTCH satellite facilities. Specifically, section 114(d)(3)(A) of the MMSEA provided that the moratorium on the increase in beds in an existing LTCH or LTCH satellite facility would not apply to an increase in beds if an existing LTCH or LTCH satellite facility is "located in a State where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State."

Section 4302(b) of the ARRA added an additional exception to the bed-increase moratorium in an existing LTCH or LTCH satellite facility "* * * if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007."

Accordingly, in the August 27, 2009 interim final rule with comment period, we revised our regulations at § 412.23(e)(7)(ii)(B) to include the new exception to the moratorium on an increase in the number of beds in existence in an existing LTCH or LTCH satellite facility beyond those in existence on December 29, 2007.

Section 4302(c) of the ARRA specifies that the "* * * effective date of the amendments made by this section shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007" (Pub. L. 110–173).

We did not receive any public comments on this provision in the August 27, 2009 interim final rule with comment period. Therefore, we are finalizing, without modification, our revision of § 412.23(e)(7)(ii)(B) to include the new exception to the moratorium on an increase in the number of beds in existence in an existing LTCH or LTCH satellite facility beyond those in existence on December 29, 2007.

F. Extension of Certain Payment Rules for LTCH Services and Moratorium on the Establishment of Certain Hospitals and Facilities and the Increase in Number of Beds in Existing LTCHs or LTCH Satellite Facilities

1. Background

As explained in the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule, sections 114(c) and (d) of MMSEA (Pub. L. 110–173, enacted December 29, 2007), made various changes to certain LTCH PPS policies. These changes were implemented in two interim final rules published in May 2008 (73 FR 24871 and 73 FR 29699). The ARRA (Pub. L. 111–5) was enacted on February 17, 2009, and section 4302 of the ARRA amended sections 114(c) and (d) of the MMSEA. These changes were implemented in an interim final rule with comment period, which was published with the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43990 through 43994). In that same rule, the MMSEA provisions that were not affected by the passage of ARRA were finalized. (For a more complete description of the MMSEA, as amended by ARRA changes to LTCH PPS policies, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43976 through 43990).

Subsequent to the passage of the ARRA, the Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) was passed. Sections 3106 and 10312 of the Affordable Care Act together provide for a 2-year extension to the payment policies applicable to LTCHs and LTCH satellite facilities set forth in sections 114(c) and (d)(1) of the MMSEA, as amended by the ARRA. Specifically, sections 3106 and 10312 of the Affordable Care Act together result in the phrase "3-year period" being replaced with the phrase "5-year period" each place it appears in sections 114(c) and (d)(1) of MMSEA, as amended by the ARRA. (The ARRA amendments, which were implemented in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43990 through 43994) are finalized in section VII. E. of this final rule.) We note that the changes required by sections 3106 and 10312 of the Affordable Care Act are self-implementing and were announced in the FY 2011 IPPS/LTCH PPS supplemental proposed rule. In that same proposed rule, we also proposed to revise the regulation text to incorporate such existing law.

Sections 3106 and 10312 of the Affordable Care Act, which amended sections 114(c) and (d)(1) of the MMSEA, as amended by the ARRA, result in the following:

- An additional 2-year delay in the application of the SSO payment adjustment, which would have applied the additional payment option of an "IPPS comparable" payment to LTCHs for certain SSO cases where the covered length of stay is less than or equal to the "IPPS comparable threshold" (75 FR 30966 and 72 FR 26904 through 26918). Therefore, the Secretary will not apply this SSO payment adjustment for the 5-year period beginning on the date of enactment of MMSEA (December 29, 2007). As proposed, in this final rule the regulations at § 412.529(c)(2) and (c)(3) are revised to incorporate this additional 2-year delay provided for under the Affordable Care Act.
- An additional 2-year delay in the one-time prospective budget neutrality adjustment to the standard Federal rate (§ 412.523(d)(3)). Thus, the Secretary is precluded from making the one-time adjustment to standard Federal rate until December 29, 2012. For a detailed description of this change, we refer readers to the discussion in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30966). As proposed, in this final rule the regulations at § 412.523(d)(3) are revised to incorporate this additional 2-year delay.
- An increase from 3 years to 5 years to the timeframes set forth in section 114(c) of the MMSEA as amended by the ARRA, thereby extending for an additional 2 years the delay in the application of the 25-percent payment threshold policy for certain LTCHs and LTCH satellite facilities (§§ 412.534 and 412.536), and extending for an additional 2 years, the increased percentage thresholds outlined at section 114(c)(2) of the MMSEA as amended by the ARRA (which is discussed in detail in section VII. E. of this final rule). As proposed, in this final rule we are amending the regulations at § 412.534(c)(1) through (c)(3), (d)(1) through (d)(3), (e)(1) through (e)(3), (h)(4) through (h)(5) and § 412.536(a)(2) to incorporate the 2-year delay and extension, as applicable, provided for under the Affordable Care Act. For a detailed description of sections 114(c)(1) and (c)(2) of the MMSEA as amended by the ARRA and the regulations implementing those provisions, we refer readers to the LTCH PPS interim final rule with comment period at 73 FR 29701 through 29704, the FY 2010 IPPS/RY 2010 LTCH PPS final rule at 74 FR 43980 through 43984, and section VII. E. of this final rule where we finalize the interim final rule with comment period implementing

section 4302 of the ARRA, which we published in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43990 through 43993).

• Additional 2-year extensions of the moratorium on the establishment of new LTCHs and LTCH satellite facilities and the moratorium on the increase of LTCH beds in existing LTCHs or satellite facilities as provided by section 114(d) of the MMSEA as amended by the ARRA. In general, section 114(d) of the MMSEA as amended by the ARRA precluded the establishment and classification of new LTCHs or LTCH satellite facilities or additional beds from being added to existing LTCHs or LTCH satellite facilities unless one of the specified exceptions to the particular moratorium was met. For a detailed description of the moratoriums, we refer readers to the discussions at 73 FR 29704 through 29707, 74 FR 43985 through 43992, and 75 FR 30968. As proposed, in this final rule we are amending the regulations at § 412.23(e)(6)(i) and (e)(7)(ii) to incorporate the additional 2-year extension of the moratoriums, discussed above.

We did not receive any public comments on the provisions as presented in the June 2, 2010 supplemental proposed rule, and therefore, in this final rule, we are finalizing these provisions as presented.

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, 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 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 (that is, CMS contractor processing of the Form CMS–855 application), 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 finds 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. Specifically, the effective date would be the date that CMS determines, pursuant to its contractor review and verification activities, that the applicant is in compliance with all enrollment requirements and CMS is prepared to convey Medicare billing privileges to the provider or supplier. However, if 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, 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 not complete or accurate, 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 CMS regulations at 42 CFR 489.18(c), a "change of ownership" includes accepting assignment of the seller's existing provider agreement or supplier approval. Section 489.18(d) states that the provider or supplier continues to be subject to the same statutes and regulations, and to the terms and conditions under which it was originally issued. This means that the new owner receives the assets and liabilities associated with that agreement or approval. This has proven to be an important tool in protecting the Medicare Trust Funds through continuity in the ability to recover outstanding overpayments.

Under that policy, if a buyer of a Medicare-participating facility chooses not to accept assignment of the provider agreement or supplier approval, the provider agreement or supplier approval terminates. Then, the new owner must be treated as an initial applicant to the Medicare program. In this situation, Medicare will not reimburse the provider or supplier for services it provides before the date on which the provider or supplier qualifies as an initial applicant.

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 accept assignment of the seller's active provider agreement could potentially begin receiving Medicare payments immediately (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. Revisions to Regulations

In the FY 2011 IPPS/LTCH proposed rule (75 FR 24047), we proposed to amend § 489.13 and make a technical amendment to § 489.1 in order to clarify our policy. Specifically, we proposed 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 noted 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 proposed 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 proposed 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 proposed 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 proposed to revise § 489.13(b) to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

In the proposed rule, we further explained 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 enrollment 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 and initial certification 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 proposed 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 proposed to revise this paragraph to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

We proposed to remove § 489.13(d), concerning the determination of the effective date for accredited facilities. We indicated that we saw 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 noted that 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.

In the proposed rule, we explained that 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 beneficiary 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, in the proposed rule, we stated that we believed it was 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 proposed to make several technical amendments to § 489.1. Specifically, we proposed 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 proposed 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.

Comment: One commenter expressed concern that the new post-survey reviews by the contractor [that is, the Medicare Administrative Contractor (MAC) or legacy fiscal intermediary or carrier] will significantly delay the effective date of new provider agreements, particularly for home health agencies that must meet certain capitalization requirements. The commenter recommended that CMS direct its contractors to perform all possible tasks in the pre-survey timeframe and to limit the post-survey tasks. The commenter also called for the contractor in the post-survey review of a home health agency application to merely require certification that the provider retains capitalization for the first 3 months of operation. The commenter further recommended that CMS establish processing timeframes for the post-survey activities of its contractors, and also require the contractors to notify the applicant's accreditation organization when the contractor recommends approval of enrollment. Finally, the commenter recommended that CMS require the accreditation organization to notify the contractor and the CMS Regional Office when a provider applicant has satisfied accreditation requirements.

Response: CMS has the regulatory authority to verify the information on an enrollment application at any time, including post-survey or post-accreditation. Further, the regulatory requirements in § 489.13 can accommodate whatever contractor (MAC or legacy fiscal intermediary/carrier) verification processes for providers and suppliers that CMS employs; such contractor verification processes are governed by the regulations under 42 CFR part 424 and associated policy instructions issued by CMS. In the proposed rule at § 489.13(b)(1), it states that CMS determines the date on which the completeness and accuracy of the enrollment application has been verified by the CMS contractor. However, we note that a second contractor review that takes place after the survey will only delay the effective date of a provider agreement or supplier approval if that review identifies noncompliance with any Federal requirements. If a provider or supplier that is subject to § 489.13 is found upon a post-survey second contractor review to continue to meet all requirements, there would be no change in the compliance determination date previously provided by the contractor to the CMS Regional Office or State survey agency. On the other hand, if the provider or supplier does not meet all Federal requirements, there would be a delay in the effective date of any provider agreement or supplier approval that might eventually be issued to the applicant.

The issues of processing timeframes or the criteria to be used in the case of a post-survey review of a home health agency applicant by the contractor, such as for capitalization, as well as the issue of notices to or from accreditation organizations are matters that are specified through manual and policy instructions by CMS rather than through regulation. However, with respect to the accreditation organizations, we note that they are already required to provide notice of their survey results and accreditation decisions to the CMS Regional Office. Further, the contractor is already required to notify the applicant when it has completed its pre-survey review of an enrollment application, and CMS instructs accreditation organizations not to conduct a survey related to an initial application for Medicare participation until the applicant provides evidence to the accreditation organization of the notice from the contractor.

Comment: One commenter expressed concern in response to our statement in the proposal that other Federal requirements that must be satisfied before a provider agreement could be effective included compliance with Office of Civil Rights (OCR) requirements. The commenter stated that the proposal to include OCR clearance before the provider agreement is made effective will significantly delay the effective date of the agreement for all but the largest entities that have a Corporate Agreement with OCR. The commenter noted that currently the provider agreement is made effective while OCR performs its compliance review. The commenter recommended that the State survey agencies and accreditation organizations review the provider's civil rights policies and procedures as part of the survey process. The commenter referred to the requirements at 42 CFR 484.12 for home health agencies and 42 CFR 418.116 for hospices as evidence of the commenter's view that State survey agencies and accreditation organizations already perform assessments of compliance with OCR requirements.

Response: We do not intend to change our current policy related to OCR compliance. Currently, in the transmittal letter sent to a prospective provider or supplier informing that a provider agreement (including its effective date) is being issued, it states that the applicant's Medicare participation is contingent upon compliance with all civil rights requirements, as determined by OCR, usually at a date later than the effective date of the provider agreement. Thus, the commenter's concern that we are changing this policy, with the result that the effective date of a provider agreement would be delayed until OCR completes its review, is unfounded; therefore, it is not necessary to consider adopting the commenter's recommendation concerning how to ameliorate the impact of a change by having State survey agency or accreditation organization assessment of OCR compliance. In our proposal, we referred to "submission of required civil rights compliance documentation" as an example of other Federal requirements that must be met. There are occasions where an applicant's required documentation of assurance of compliance with civil rights laws and regulations, Form HHS–690, and related documents, are not submitted until after a survey is conducted. In such cases, the effective date of the provider agreement may not be prior to the date when the complete required civil rights compliance documentation was received by CMS.

Although it is not necessary to consider the commenter's recommendation of State or accreditation organization assessment of compliance with OCR requirements in view of there being no change in our current practice concerning OCR compliance determinations, we do note that the commenter's assumption concerning who makes such compliance determinations is not correct. OCR has the authority to determine compliance with Federal civil rights requirements; CMS does not have such authority. Although there generally are requirements in the various CMS regulations for providers, including home health and hospice agencies, to comply with applicable Federal, State, and local law, such requirements do not mean that CMS has in all, or even most, cases the authority to determine compliance with such law. Where CMS does not have such authority, CMS and the State survey agencies and accreditation organizations must rely upon the determinations of the agencies that do have such authority before they find a provider to be noncompliant with a CMS provision requiring compliance with other laws.

Comment: Two commenters expressed concern with the proposal to remove the provisions of § 489.13(d)(2), which gives CMS the discretion to make the effective date of a provider agreement or supplier approval retroactive up to 1 year. One commenter stated that this would remove an important flexibility in how the effective date is established, resulting in unnecessary delays in enrollment, and may inadvertently limit access to Medicare services or inappropriately shift the costs of caring for Medicare beneficiaries to providers. This commenter indicated that CMS provided no analysis of how this change would reduce fraud and abuse. Another commenter stated that a "snafu" in an accreditation organization may result in excessive delay in its issuing its accreditation decision, and recommended that CMS retain its authority for retroactive effective dates for deemed accredited facilities and specify in the regulation that such authority will be exercised only when equity so requires and when the accrediting determination delay was due to no fault of the provider or supplier.

Response: The commenters' concerns that removal of § 489.13(d)(2) would eliminate a current flexibility and, therefore, would result in unnecessary delays in Medicare enrollment are not warranted because we have not exercised the discretion afforded to us in this provision. This was a discretionary provision that we have not utilized for the reasons noted in the preamble to the proposed rule. Further, we do not believe that the accreditation of a facility should afford the facility preferential treatment in its provider agreement or supplier approval effective date determination compared to a nonaccredited facility that chooses to be surveyed by the State agency or CMS.

With respect to the rationale for deleting this provision in order to protect the Medicare Trust Funds, as we stated in the proposed rule, exercising the discretion to permit such retroactive effective dates for accredited facilities would seriously undermine our policy concerning accepting assignment of the seller's provider agreement or supplier approval. As a matter of longstanding policy reflected in issuances dating as far back as 1994, new owners of existing providers or suppliers who do not accept the seller's existing Medicare provider agreement or supplier approval and who intend to continue Medicare participation are treated as new applicants to the Medicare program and must submit to the same process as any new provider or supplier. This process necessarily entails a break in Medicare payment for services provided during the period between the termination of the seller's provider agreement and the issuance of a new provider agreement to the new owner. As a result, new owners of a Medicare participating facility must carefully weigh the costs and benefits of their decision of whether or not to assume the seller's existing Medicare provider agreement. Thus, the Medicare Trust Funds are better protected because new owners generally decide to assume the seller's provider agreement, including outstanding liabilities (such as any overpayments or money penalties) owed to the Medicare program. In some cases, this would also result in the new owner receiving any outstanding Medicare underpayments owed under the existing agreement. In the State Operations Manual (Pub. 100–07) and in the October 17, 2008 Survey and Certification Memorandum S&C–09–08, we explicitly stated that accredited facilities also are subject to the policy requiring new owners who reject assignment of the seller's existing provider agreement to be treated as an initial applicant to the Medicare program, with the break in coverage that this entails. If, on the other hand, a new owner of an accredited provider who chooses not to accept assignment of the seller's existing Medicare provider agreement could be issued a new provider agreement on the basis of deemed status with a retroactive effective date that bridged the coverage gap since the termination of the seller's provider agreement, then this would provide a strong incentive for new owners to routinely refuse to accept assignment of the seller's provider agreement. The resulting impact on the Medicare Trust Funds would be negative, in terms of both any outstanding liabilities owed to the Medicare program under the seller's terminated provider agreement or supplier approval and the cost of paying for services provided by a new applicant prior to the date when that applicant satisfies all Federal requirements.

Finally, delay in issuance of an accreditation decision due solely to internal administrative issues within the accreditation organization should not, contrary to the commenter's concern, delay the effective date of the accreditation decision, and thus the effective date of the applicant's provider agreement or supplier approval. The standard practice expected for Medicare-approved accreditation

programs is for the accreditation organizations to make their accreditation decision effective as of the date that all accreditation program requirements were met, regardless of when the decision is actually issued. We are revising the regulatory text upon adoption to make this clearer. In view of this standard practice and in light of the fact that the retroactive effective date provision for accredited providers and suppliers has not been utilized by us, we do not believe there is need to retain the ability to make retroactive provider agreement or supplier approval effective date determinations in the case of accredited facilities.

Comment: One commenter stated that it was not clear whether CMS intended § 489.13 to apply to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) applicants, but indicated that the issues presented in the proposed rule do not apply to DMEPOS supplier enrollment.

Response: We did not propose any changes with respect to the entities that are covered by the provisions of § 489.13. Generally, these provisions do not apply to DMEPOS applicants because they are not subject to our survey and certification process. However, because there are now Medicare accreditation requirements for certain types of suppliers that are not subject to the survey and certification process, we understand why the commenter was unclear about this application. As a result, we have revised the final regulatory text at § 489.13(a)(1)(ii) to indicate that this provision applies to providers and suppliers that are subject to survey by a State survey agency or CMS, or, in lieu of such survey, are accredited by an accreditation organization whose program has CMS approval in accordance with section 1865 of the Act at the time of the accreditation survey and accreditation decision. Because accreditation requirements for certain Medicare suppliers, such as DMEPOS and imaging services suppliers, are established under sections 1834(a) and (e) of the Act rather than section 1865 of the Act, this revision to the regulation makes it clear that the provisions of § 489.13 do not apply to these other supplier types.

After consideration of the public comments we received, we are adopting as final our proposed revisions of § 489.13(a), (b), and (c), removal of existing § 489.13(d), and technical amendments to § 489.1, with the following modifications and technical corrections:

We have revised § 489.13(a)(1)(i) to delete the word "staff" after "CMS". This word was inadvertently included in the proposed text, but, as we stated in the preamble to the proposed rule, the intent is to cover surveys conducted by CMS staff or contractors.

We have revised § 489.13(a)(1)(ii) to add a reference to accreditation programs approved in accordance with section 1865 of the Act, thus making it clear that § 489.13 is applicable only to providers and suppliers that are subject to CMS or State survey or, in lieu of such survey, are accredited by an accreditation organization whose program has CMS approval in accordance with section 1865 of the Act. Also, we are adding the word "survey" in paragraph (a)(1)(ii) so that it states "State survey agency"; this change will make this paragraph consistent with § 489.13(a)(1)(i).

We have revised § 489.13(b) to add the word "effective" prior to "date of the accreditation decision" in order to make clear our intent that we are referring to the date an accreditation organization indicates its accreditation was effective.

We have revised § 489.13(c) to reword the final sentence of the introductory text as follows: "However, if other Federal requirements remain to be satisfied, notwithstanding the provisions of paragraphs (c)(1) through (c)(3) of this section, 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" We added the phrase "CMS determines that" prior to "each applicable Federal requirement is met" to correct an inadvertent omission that could have created ambiguity as to our intent and makes the language in paragraph (c) match that employed in § 489.13(b) for the same purpose. We also added the above language to make it clear that the provisions in paragraphs (c)(1) through (c)(3) apply when all other Federal requirements have been met, but where this is not the case, the effective date would be the latest date.

We have renumbered proposed § 489.13(c)(2)(ii)(C) as final § 489.13(c)(3), which was our original intent; this paragraph is a logically distinct provision from other provisions contained in § 489.13(c)(2).

We have made conforming changes to § 424.510(c) and § 424.520(a) by removing the cross-reference to paragraph (d) of § 489.13.

IX. Medicare Hospital Conditions of Participation Affecting 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 only specific qualified, licensed practitioners (including physicians, 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. 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 is too open to interpretation and does not explicitly acknowledge various State laws that limit the ordering of hospital services (including diagnostic tests, drugs and biologicals, and inpatient treatment modalities) to specific qualified, licensed practitioners who are responsible for the care of the patient.

By contrast, the current requirement for respiratory care services at § 482.57(b)(3), which explicitly states that these services "must be provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy," is 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 CoPs with each other, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24050), we proposed several revisions to the existing regulations. We proposed to revise § 482.56 to clarify the types of practitioners that are allowed to order rehabilitation services. Further, we proposed 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 proposed 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 proposed 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 proposed 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 proposed that all orders for these services be documented in accordance with the requirements at § 482.24, Medical records.

Comment: The majority of commenters supported the proposed changes for the CoPs for rehabilitation services and respiratory care services. Some of the commenters commended CMS for proposing changes that they believed accurately reflected current standards of practice. Many of the commenters supported the proposed changes focused exclusively on the proposed requirements for respiratory care services.

Response: We appreciate the commenters' support for the proposed changes. We believe that many of the commenters focused exclusively on the proposed revisions to the respiratory care services CoP because these revisions would allow for qualified, licensed practitioners, such as NPs and PAs, to order respiratory care services in addition to physicians, that is, doctors of medicine and doctors of osteopathy, as is currently allowed under the requirements. While we believe that the proposed change to the rehabilitation services CoP is more of a clarification of which types of practitioners (as delineated by State law, hospital policy, and medical staff authorization) would be allowed to order such services, we believe that the proposed revision to the respiratory care services CoP represents a regulatory recognition of the qualifications that nonphysician practitioners, such as NPs and PAs, bring to hospital patient care and that this recognition accounts for many of the commenters focusing exclusively on the change to this CoP.

Comment: Several commenters questioned what they saw as an exclusion from the proposed rule of other types of advanced practice registered nurses (APRNs) (for example, clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs)), as well as rehabilitation professionals such as physical therapists (PTs) and speech-language pathologists (SLPs).

Response: Our intention was not to exclude other types of nonphysician practitioners such as APRNs, PTs, SLPs, or other types of rehabilitation professionals from the proposed rule provisions. We recognize the important role that these practitioners and professionals play in the delivery of quality care to hospital patients. We point out that the proposed regulatory language does not specifically mention any "type "of practitioner, including NPs and PAs. Instead, the proposed revisions to both CoPs would require that services be provided only under the orders of a qualified, licensed practitioner, responsible for the care of the patient, acting within his or her scope of practice, and authorized by the medical staff to order the services in accordance with hospital policies and procedures and all State laws. Although NPs and PAs were the only examples of practitioner types that we used in our discussion of the proposed changes in the preamble of the proposed rule, our intention, as reflected in the proposed regulation text, is to include those qualified, licensed practitioners who meet the parameters of the proposed requirements discussed above.

Comment: A few commenters took exception to our discussion in the preamble of conflict of interest and coordination of care issues in the context of rehabilitation professionals (such as PTs and SLPs) who might order their own rehabilitation services for a hospital patient without the knowledge of the attending physician or of the practitioner responsible for the overall care of the patient (such as APRNs and PAs). They questioned "why CMS would conclude that these problems [conflict of interest and coordination of care] would occur in the outpatient hospital setting when patients receive rehabilitation services," and asked that the final rule not adopt language that would exclude rehabilitation professionals from acting within their individual State's scope of practice. One commenter suggested that language distinguishing between hospital inpatient and outpatient rehabilitation services be added to the proposed requirement at § 482.56(b).

Response: The proposed requirements would apply to both inpatient and outpatient hospital services. Because the language allows for the ordering of rehabilitation services based on (and in deference to) State laws and scope-of-practice acts, medical staff authorization, and hospital policies and procedures, we firmly believe that nothing in our proposed requirement would preclude a hospital rehabilitation professional from acting within the scope of practice under State law. For this reason also, we disagree that the requirement needs to make distinctions between inpatients and outpatients.

Comment: A few commenters correctly pointed out that the hospital CoPs apply to both inpatient and outpatient services. With regard to this application of the hospital CoPs to the outpatient services of a hospital, they commented that the proposed changes would be in direct conflict with both CMS payment policy, which they state allows for rehabilitation professionals to order their own services for hospital outpatients without physician referral, and the regulations of some States, which they state allow for "direct access" to rehabilitation services for hospital outpatients.

Response: As we have previously stated, we do not believe that the proposed changes would conflict with either CMS payment policy or State

regulations. In fact, we have drafted the regulatory text in a way that would not only defer to hospital policy and medical staff authority in granting ordering privileges for these services to qualified, licensed practitioners, but also to State laws and scope-of-practice acts. We believe that these proposed regulations would give hospitals and their medical staffs as much flexibility in determining which types of practitioners could order these services as they would choose to exercise within the constraints of their own State laws and regulations.

Comment: One commenter noted that as many as 35 States have some form of regulatory language that states, in effect, that hospital respiratory care services orders must be "written by a licensed physician only."

Response: As stated in our previous response, the proposed regulations are written in such a way as to avoid the preemption of State law and regulation. We expect hospitals to apply the laws of their respective States to their policy regarding which types of practitioners would be allowed to order respiratory care services. For those States that allow APRNs and PAs to order respiratory care services without the need for a physician co-signature, we expect hospitals in those States to determine which types of practitioners would be authorized by the medical staff to write these orders in accordance with State law. We also expect that practitioners will act within the limitations of their individual State laws and hospitals' policies.

Comment: One commenter requested that changes similar to the ones proposed be made to other hospital CoPs, such as nuclear medicine and dietary services, and their interpretive guidelines, and also specifically proposed changes to § 482.25(b)(6) to require that "drug administration errors, adverse drug reactions, and incompatibilities be immediately reported to the ordering practitioner." In addition, the commenter recommended that the interpretative guidelines issued for § 482.24(c)(1) be revised.

Response: While we appreciate the input from the commenter regarding the other hospital CoPs and the interpretative guidelines, changes to other CoPs are outside the scope of this final rule. Any revisions to the interpretative guidelines are outside the purview of the rulemaking process.

Comment: A few commenters, in addition to voicing full support for the proposed changes, encouraged CMS to revise the CoPs and interpretative guidelines regarding the administration of propofol (a rapidly acting, short duration, intravenous hypnotic anesthetic induction agent used as a general anesthetic or as an adjunct to anesthesia) by an anesthesiologist or CRNA in the context of recognition of State laws addressing this issue.

Response: As we stated in our previous response, while we appreciate the input from commenters, we cannot address it at this time because the issues are outside the scope of this rule. Furthermore, any revision of the interpretative guidelines would be outside the purview of the rulemaking process.

After consideration of the public comments we received, we are adopting as final without modification, our proposals to revise § 482.56 and § 482.57 to clarify the types of practitioners who are allowed to order rehabilitation services and respiratory care services, respectively in accordance with both hospital policies and procedures and State laws; and to provide that all orders for these services be documented in accordance with existing requirements at § 482.24.

X. 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 Federal regulatory 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 from 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. Revision of Policy and Regulations

In response to the concerns described above, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24051), we proposed to remove the requirement that psychiatric hospitals and hospitals with inpatient psychiatric programs providing inpatient psychiatric services to individuals under age 21 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 undergoing a State survey to determine whether the hospital meets 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. Likewise, hospitals with inpatient psychiatric programs would have the choice of undergoing a State survey to determine whether the hospital meets 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 proposed 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 have removed 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 a provider or supplier type that are comparable to the CMS requirements for the type of provider or supplier, and must have survey procedures comparable to those of State survey agencies. For the reasons described below, we are not finalizing this proposed change to the PRTF accreditation requirements, and will retain the language currently set out at 42 CFR 440.160 (b)(2) and 441.151(a)(2)(ii).

To incorporate the proposed changes described above in our regulations, we proposed 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. We also proposed to revise § 440.160(b)(2) and § 441.151(a)(2)(ii) by removing references to specific accreditation organizations.

Comment: Several commenters supported the proposed revisions. These commenters agreed with CMS' assessment that allowing increased flexibility for psychiatric hospitals and inpatient psychiatric programs within general hospitals to either obtain accreditation from a CMS-approved accrediting organization or adhere to Medicare standards would not negatively impact the quality of service provision. Most of these commenters were silent regarding the proposed changes to the PRTF language, which would have removed reference to specific accrediting organizations. However, one commenter expressed support for this proposed change as well.

Response: We appreciate the commenters' support. However, we are not finalizing the proposed changes to the PRTF accreditation requirements. We have decided that changes to these provisions are unnecessary because our regulations already permit a PRTF to be accredited by a variety of accrediting bodies. Our current provisions are not proscriptive. The Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, and the Commission on Accreditation of Rehabilitation Facilities will remain available to accredit PRTFS, as will any other accrediting organizations with comparable standards that are recognized by the States.

Comment: One comment indicated that "CMS must remain the sole accreditation agency for psychiatric facilities as well as emergency rooms (ERs)". The commenter further stated that third party accreditation would not maintain the same level of adherence to the restraint and seclusion regulatory requirement.

Response: We have never been the "sole accreditation agency" for these providers. CMS approves third party accrediting organizations to perform the accreditation reviews. The restraint and seclusion CoP is a requirement that is surveyed by CMS and/or the accreditation organizations, as applicable.

Comment: One commenter offered suggestions to improve the care provided to individuals in psychiatric settings. The commenter's suggestions included telling patients the names of all medications being given; developing a written treatment plan; keeping patients clean; and utilizing a "comfort room" for patients who are in critical condition.

Response: Although we appreciate these suggestions, they fall outside the scope of the proposed rule. We did solicit public comments on our proposed accreditation revisions for inpatient psychiatric services provided to children. However, these comments appear to address the overall care furnished in psychiatric settings. Existing regulations governing psychiatric hospitals, general hospitals, and PRTFs currently require that the beneficiary receive care based upon an individualized treatment plan. We do not anticipate that patients in critical condition (life-threatening medical situations) would be maintained in the psychiatric inpatient setting, but rather would be transferred to a medically appropriate facility. We encourage all providers, including those furnishing inpatient psychiatric services to individuals under age 21, to bring an attitude of respect to the treatment process, caring for patients in a way that maximizes information sharing and comprehensive care. However, we are not modifying the regulations for this specific service to include these suggestions.

After consideration of the public comments we received, we are adopting as final, without modification, our proposed revision of § 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. Under the final regulations, psychiatric hospitals will have the choice of undergoing a State survey to determine whether the hospital meets 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. Likewise, hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey to determine whether the hospital meets 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.

As described above, we are not finalizing our proposed revision of § 440.160(b)(2) and § 441.151(a)(2)(ii) to remove 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. The language currently specified in § 440.160(b)(2) and § 441.151(a)(2)(ii) is being retained.

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 consideration in conjunction with the policies set forth in this final 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 final 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 final rule, our current estimate is that an aggregate adjustment of 9.7 percent (in addition to the −0.6 percent adjustment and the −0.9 percent adjustment previously made in FY 2008 and FY 2009, respectively) is necessary to satisfy these requirements.

We discuss the public comments we received on the FY 2011 IPPS/LTCH PPS proposed rule, and our responses, regarding 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 final rule for IPPS operating payments, in section V.E. of the preamble of this final rule for IPPS capital payments, and in section VII.C.3. of the preamble of this final 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.* We listed the data files and the cost for each file, if applicable, in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24052 and 24053).

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

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, 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.

2. Requirements in Regulation Text

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24054 through 24056), we solicited public comment on each of these issues listed in section XII.B.1. of this preamble for the following sections of this document that contain information collection requirements (ICRs). We discuss and respond to any public comments we received in each individual section.

a. ICRs Regarding Withdrawing an Application, Terminating an Approved 3-Year Reclassification, or Canceling a Previous Withdrawal or Termination (Revised § 412.273)

We have revised much of § 412.273 to make the provisions clearer and more easily understood. Although the majority of the information collections under this section exist under current law, as we are modifying the provision, in this section we discuss the information collections that will exist under the revised § 412.273.

As discussed in section III.I. of this preamble, 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. Revised § 412.273(c) further specifies the timing requirements for the withdrawal or termination requirements. Revised § 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).

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).

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. Revised § 412.273(d)(2) requires 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).

Section 412.273(d)(3) states that a hospital will 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.

Section 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 the PRA, the associated burden is exempt under 5 CFR 1320.4. The burden associated with collection 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)

Section IX. of this preamble discusses the revisions to § 482.57(b)(4), which impose a recordkeeping requirement. Section 482.57(b)(4) requires all respiratory care services orders to be documented in the patient's medical record in accordance with 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 final rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

a. Present on Admission (POA) Indicator Reporting

Section II.F.6. of the preamble of this final rule discusses the POA indicator reporting program. As stated earlier, collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request 5499 dated May 11, 2007, CMS issued instructions that require IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims.

The burden associated with this requirement is the time and effort necessary to place the appropriate POA indicator codes on Medicare claims. This requirement is subject to the PRA; however, the associated burden is currently approved under OMB control number 0938–0997, with an expiration date of October 31, 2012.

b. Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of this final rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold. We detailed the burden associated with this requirement in the September 7, 2001, IPPS final rule (66 FR 46902). As stated in that final rule, collection of the information for this requirement is conducted on an individual case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Similarly, we also believe the burden associated with this requirement is exempt from the PRA under 5 CFR 1320.3(c), which defines the agency collection of information subject to the requirements of the PRA as information collection imposed on 10 or more persons within any 12-month period. This information collection does not impact 10 or more entities in a 12-month period. In FYs 2008, 2009, 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 IV.A. of this final 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 the FY 2011 IPPS/LTCH PPS proposed rule, we proposed to retire one measure for the FY 2011 payment determination (75 FR 23961). For the FY 2012 through FY 2014 payment determinations, we proposed 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 listed 28 new measures that are under consideration for adoption in future years. We proposed that, beginning with CY 2011 discharges, hospitals submit some of the new measure data to a qualified registry.

We also solicited 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 proposed to retire one measure for the FY 2011 annual payment update and sought 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 proposed 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 proposed 28 possible measures and topics for future years. Finally, we proposed 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 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 IV.A.10. of the FY 2011 IPPS/LTCH PPS proposed rule addressed 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.

For the FY 2011 annual payment update, we are retiring the AHRQ mortality for selected surgical procedures composite measure. We refer readers to section IV.A.3. of this final rule for the list of RHQDAPU measures that we are adopting as final for FY 2012 through FY 2014. Over the three year period, we are retiring 2 additional measures from the measurement set (PN–2, and PN–7) and adding 17 new measures to the measure set, for a total of 60 measures. We are not adopting any of our proposed registry-based measures, or our proposal for all-patient volume reporting.

In summary, after consideration of the public comments we received, we are:

- Retiring one measure for the FY 2011 annual payment update.
- Retaining the measures used for the FY 2011 annual payment update (except for the 1 we are retiring) and adopting 10 additional claims—based measures for reporting in 2011 that will be used to determine the FY 2012 annual payment update.
- Retaining the measures used for the FY 2012 annual payment update and adopting an additional 1 chart-abstracted measure and 1 HAI measure (to be reported through the NHSN) for reporting in 2011 that will be used to determine the FY 2013 annual payment update.
- Retaining the measures used for the FY 2013 annual payment update (except for 2 measures we are retiring) and adopting 5 additional measures for reporting in 2012 that will be used to determine the FY 2014 annual payment update.

d. Occupational Mix Adjustment to the FY 2011 Index (Hospital Wage Index Occupational Mix Survey)

Section II.D. of the preamble of this final rule discusses the occupational mix adjustment to the FY 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 final rule discusses revisions to the wage index based on hospital redesignations. As stated in that section, under section 1886(d)(10) of the Act, the

MGCRB has the authority to accept short-term IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests by hospitals for geographic reclassification for purposes of payment under the IPPS.

The burden associated with this application process is the time and effort necessary for an IPPS hospital to complete and submit an application for reclassification to the MGCRB. While this requirement is subject to the PRA, 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 final rule, as we proposed, we are allowing 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 electronic submission process will consist of either an e-mail mailbox or a Web site where hospitals will submit their Medicare GME affiliation agreements to the CMS Central Office to a designated online mailbox. We are providing that a copy of the Medicare GME affiliation agreement will need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are specifying that the electronic affiliation agreement will need to be submitted either as a scanned copy or a Portable Document Format (PDF) version of that hard copy agreement; we will not 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 policy, hospitals will 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 will 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 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 × 125 agreements).

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 415

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

42 CFR Part 424

Conditions for Medicare payment.

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 recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

■ 2. Section 412.2 is amended by—

■ a. Revising paragraph (c)(5) introductory text.

■ b. Revising paragraph (c)(5)(iii).
■ c. Adding a new paragraph (c)(5)(iv).

The revision and addition read as follows:

§ 412.2 Basis of payment.

* * * * *

(c) * * *

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the condition specified in paragraph (c)(5)(i) of this section and at least one of the conditions specified in paragraphs (c)(5)(ii) through (c)(5)(iv).

* * * * *

(iii) For services furnished on or after October 1, 1991, through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

■ 3. Section 412.4 is amended by—
■ a. Republishing the introductory text 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.

* * * * *

§ 412.23 [Amended]

■ 4. In § 412.23, paragraphs (e)(6)(i) and (e)(7)(ii) are amended by removing the date "December 28, 2010" and adding the date "December 28, 2012" in its place.

■ 5. Section 412.64 is amended by—
■ a. Revising paragraphs (d)(1) and (e)(4).
■ b. Adding a new paragraph (m).

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(d) * * *

(1) Subject to the provisions of paragraph (d)(2) of this section, the applicable percentage change for updating the standardized amount is—

(i) For fiscal year 2005 through fiscal year 2009, the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(ii) For fiscal year 2010, for discharges—

(A) On or after October 1, 2009 and before April 1, 2010, the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas; and

(B) On or after April 1, 2010 and before October 1, 2010, the percentage increase in the market basket index minus 0.25 percentage points for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(iii) For fiscal year 2011, the percentage increase in the market basket index minus 0.25 percentage points for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

* * * * *

(e) * * *

(4) 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 paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions as follows:

(i) Beginning October 1, 2008, such adjustment is transitioned from a nationwide to a statewide adjustment as follows:

(A) From October 1, 2008 through September 30, 2009, the wage index is a blend of 20 percent of a wage index with a statewide adjustment and 80 percent of a wage index with a nationwide adjustment.

(B) From October 1, 2009 through September 30, 2010, the wage index is a blend of 50 percent of a wage index with a statewide adjustment and 50 percent of a wage index with a nationwide adjustment.

(ii) Beginning October 1, 2010, such adjustment is a full nationwide adjustment.

* * * * *

(m) *Adjusting the wage index to account for the Frontier State floor.*

(1) *General criteria.* For discharges occurring on or after October 1, 2010, CMS adjusts the hospital wage index for hospitals located in qualifying States to recognize the wage index floor established for frontier States. A qualifying frontier State meets both of the following criteria:

(i) At least 50 percent of counties located within the State have a reported population density less than 6 persons per square mile.

(ii) The State does not receive a nonlabor-related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of wage index adjustment.* A hospital located in a qualifying State will receive a wage index value not less than 1.00.

(3) *Process for determining and posting wage index adjustments.* (i) CMS uses the most recent Population Estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will include a listing of qualifying frontier States and denote the hospitals receiving a wage index increase attributable to this provision in its annual updates to the hospital inpatient prospective payment system published in the **Federal Register**.

■ 6. Section 412.73 is amended by—
■ a. Revising paragraph (c)(15).
■ b. Adding a new paragraph (c)(16).

The revision and addition read as follows:

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(c) * * *

(15) *For Federal fiscal year 2003 through Federal fiscal year 2009.* For Federal fiscal year 2003 through Federal fiscal year 2009, the update factor is the percentage increase in the market basket

index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(16) *For Federal fiscal year 2010 and subsequent years.* For Federal fiscal year 2010 and subsequent years, the update factor is the percentage increase specified in § 412.64(d).

* * * * *

§ 412.75 [Amended]

■ 7. In § 412.75, paragraph (d) is amended by removing the citation "§ 412.73(c)(15)" and adding the citation "§ 412.73(c)(15) and § 412.73(c)(16)" in its place.

§ 412.77 [Amended]

■ 8. In § 412.77, paragraph (e) is amended by removing the reference "(c)(15)" and adding the reference "(c)(16)" in its place.

§ 412.78 [Amended]

■ 9. In § 412.78, paragraph (e) is amended by removing the citation "§ 412.73(c)(15)" and adding the citation "§ 412.73(c)(15) and § 412.73(c)(16)" in its place.

§ 412.79 [Amended]

■ 10. In § 412.79, paragraph (d) is amended by removing the phrase "and (c)(15)" and adding the phrase "through (c)(16)" in its place.

■ 11. Section 412.101 is revised to read as follows:

§ 412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *Definitions.* Beginning in FY 2011, the terms used in this section are defined as follows:

Medicare discharges means discharge of inpatients entitled to Medicare Part A, including discharges associated with individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C.

Road miles means "miles" as defined in § 412.92(c)(1).

(b) *General considerations.* (1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (c) of this section.

(2) In order to qualify for this adjustment, a hospital must meet the following criteria:

(i) For FY 2005 through FY 2010 and FY 2013 and subsequent fiscal years, a hospital must have fewer than 200 total discharges, which includes Medicare and non-Medicare discharges, during the fiscal year, based on the hospital's most recently submitted cost report, and be located more than 25 road miles (as defined in paragraph (a) of this section) from the nearest "subsection (d)" (section 1886(d) of the Act) hospital.

(ii) For FY 2011 and FY 2012, a hospital must have fewer than 1,600 Medicare discharges, as defined in paragraph (a) of this section, during the fiscal year, based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS, and be located more than 15 road miles, as defined in paragraph (a) of this section, from the nearest "subsection (d)" (section 1886(d) of the Act) hospital.

(3) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary or Medicare administrative contractor with sufficient evidence that it meets the distance requirement specified under paragraph (b)(2) of this section. The fiscal intermediary or Medicare administrative contractor will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

(c) *Determination of the adjustment amount.* The low-volume adjustment for hospitals that qualify under paragraph (b) of this section is as follows for the applicable fiscal year:

(1) For FY 2005 through FY 2010 and FY 2013 and subsequent fiscal years, the adjustment is an additional 25 percent for each Medicare discharge.

(2) For FY 2011 and FY 2012, the adjustment is as follows:

(i) For low-volume hospitals with 200 or fewer Medicare discharges (as defined in paragraph (a) of this section), the adjustment is an additional 25 percent for each Medicare discharge.

(ii) For low-volume hospitals with Medicare discharges (as defined in paragraph (a) of this section) of more than 200 and fewer than 1,600, the adjustment for each Medicare discharge is an additional percent calculated using the formula [(4/14)—(number of Medicare discharges/5600)]. The "number of Medicare discharges" is determined as described in paragraph (b)(2)(ii) of this section.

(d) *Eligibility of new hospitals for the adjustment.* For FYs 2005 through 2010 and FY 2013 and subsequent fiscal years, a new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets discharge requirements during the applicable fiscal year and has provided its fiscal intermediary or Medicare administrative contractor with sufficient evidence that it meets the distance requirement, as specified under paragraph (b)(2) of this section.

§ 412.106 [Amended]

■ 12. 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]

■ 13. Section 412.108 is amended as follows:

■ a. In paragraph (a)(1) introductory text, the phrase "before October 1, 2011" is removed and the phrase "before October 1, 2012" is added in its place.

■ b. In paragraph (a)(1)(iii) introductory text, the word "receiving" is removed and the phrase "entitled to" is added in its place.

■ c. In paragraph (c)(2)(iii) introductory text, the phrase "before October 1, 2011" is removed and the phrase "before October 1, 2012" is added in its place.

■ 14. 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.

* * * * *

■ 15. Section 412.211 is amended by revising paragraph (c) to read as follows:

§ 412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

* * * * *

(c) *Computing the standardized amount.* CMS computes a Puerto Rico standardized amount that is applicable to all hospitals located in all areas. The applicable percentage change for updating the Puerto Rico specific standardized amount is as follows:

(1) For fiscal year 2004 through fiscal year 2009, increased by the applicable percentage change specified in § 412.64(d)(1)(ii)(A).

(2) For fiscal year 2010, increased by the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(3) For fiscal year 2011, increased by the applicable percentage change specified in § 412.64(d)(1)(iii).

* * * * *

§ 412.230 [Amended]

■ 16. In § 412.230 paragraph (d)(1)(iv)(E) is amended by removing the figures "86" and "88" adding the figures "82" and "84" in their place, respectively.

§ 412.232 [Amended]

■ 17. In § 412.232, paragraph (c)(3) is amended by removing the figure "88" and adding the figure "85" in its place.

§ 412.234 [Amended]

■ 18. In § 412.234, paragraph (b)(3) is amended by removing the figure "88" and adding the figure "85" in its place.

■ 19. 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 must 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.

■ 20. A new § 412.405 is added to read as follows:

§ 412.405 Preadmission services as inpatient operating costs under the inpatient psychiatric facility prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services if the inpatient operating costs are for—

(a) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the inpatient psychiatric facility that meet the following conditions:

(1) The services are furnished by the inpatient psychiatric facility or by an entity wholly owned or wholly operated by the inpatient psychiatric facility. An entity is wholly owned by the inpatient psychiatric facility if the inpatient psychiatric facility is the sole owner of the entity. An entity is wholly operated by an inpatient psychiatric facility if the inpatient psychiatric facility has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the inpatient psychiatric facility also has policymaking authority over the entity.

(2) The services are diagnostic (including clinical diagnostic laboratory tests).

(3) The services are nondiagnostic when furnished on the date of the beneficiary's inpatient admission, the services are nondiagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not demonstrate that such services are unrelated to the beneficiary's inpatient

admission, and are not one of the following:

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

(b) The preadmission services are furnished on or after June 25, 2010.

■ 21. 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.

* * * * *

§ 412.521 [Amended]

■ 22. In paragraph (b)(1) of § 412.521, remove the reference "§ 412.2(c)" and add in its place the reference "§§ 412.2(c)(1) through (c)(4) of this Part and § 412.540".

■ 23. Section 412.523 is amended by—

■ a. Revising paragraph (c)(3)(vi).

■ b. Adding paragraph (c)(3)(vii).

■ c. In paragraph (d)(3), removing the phrase "December 29, 2010, and by no later than October 1, 2012" and adding the phrase "December 29, 2012," in its place.

The revision and addition read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(vi) *For long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010.* (A) The standard Federal rate for long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 1.74 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate in paragraph (c)(3)(v) of this section updated by 2.0 percent.

(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 −0.49 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

■ 24. 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) * * *

(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.

* * * * *

§ 412.529 [Amended]

■ 25. In § 412.529, paragraphs (c)(2) introductory text and (c)(3) introductory text are amended by removing the date "December 29, 2010" and adding in its place the date "December 29, 2012" each time it appears.

§ 412.534 [Amended]

■ 26. Section 412.534 is amended as follows:

■ a. Paragraphs (c)(1) introductory text, (c)(1)(i), (c)(1)(ii), (c)(2) introductory text, (d)(1) introductory text, (d)(1)(i), (d)(2) introductory text, (e)(1) introductory text, (e)(1)(i), and (e)(2) introductory text are amended by removing the date "October 1, 2010" and adding in its place the date "October 1, 2012" each time it appears.

■ b. Paragraphs (c)(3), (d)(3), (e)(3), (h)(4), and (h)(5) are amended by removing the date "July 1, 2010" and adding in its place the date "July 1, 2012" each time it appears.

§ 412.536 [Amended]

■ 27. In § 412.536, paragraph (a)(2) introductory text is amended by removing the date "July 1, 2010" and adding in its place the date "July 1, 2012" in its place.

■ 28. A new § 412.540 is added to read as follows:

§ 412.540 Method of payment for preadmission services under the long-term care hospital prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(a) Otherwise payable under Medicare Part B;

(b) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the long-term care hospital, or to an entity wholly owned or wholly operated by the long-term care hospital; and

(1) An entity is wholly owned by the long-term care hospital if the long-term care hospital is the sole owner of the entity.

(2) An entity is wholly operated by a long-term care hospital if the long-term care hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the long-term care hospital also has policymaking authority over the entity.

(c) Related to the inpatient stay. A preadmission service is related if—

(1) It is diagnostic (including clinical diagnostic laboratory tests); or

(2) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(3) On or after June 25, 2010, it is nondiagnostic when furnished on the

calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(d) Not one of the following—

(1) Ambulance services.

(2) Maintenance renal dialysis services.

■ 29. Section 412.604 is amended by—

■ a. Redesignating paragraph (f) as paragraph (g).

■ b. Adding a new paragraph (f).

The addition reads as follows:

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation services.

* * * * *

(f) The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(1) Otherwise payable under Medicare Part B;

(2) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the inpatient rehabilitation facility, or to an entity wholly owned or wholly operated by the inpatient rehabilitation facility; and

(i) An entity is wholly owned by the inpatient rehabilitation facility if the inpatient rehabilitation facility is the sole owner of the entity.

(ii) An entity is wholly operated by an inpatient rehabilitation facility if the inpatient rehabilitation facility has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the inpatient rehabilitation facility also has policymaking authority over the entity.

(3) Related to the inpatient stay. A preadmission service is related if—

(i) It is diagnostic (including clinical diagnostic laboratory tests); or

(ii) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(iii) On or after June 25,, 2010, it is nondiagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(4) Not one of the following—

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

* * * * *

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

■ 30. 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 Pub. L. 106–133 (113 Stat. 1501A–332).

■ 31. Section 413.40 is amended by—

■ a. Revising paragraph (c)(2) introductory text.

■ b. Revising paragraph (c)(2)(iii).

■ c. Adding a new paragraph (c)(2)(iv).

The revision and addition read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) * * *

(2) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the calendar day immediately preceding the date of the beneficiary's admission to the hospital that meet the condition specified in paragraph (c)(2)(i) of this section and at least one of the conditions specified in paragraphs (c)(2)(ii) through (c)(2)(iv):

* * * * *

(iii) For services furnished on or after October 1, 1991 through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis services.

(iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

* * * * *

■ 32. 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).

■ d. Revise paragraph (b)(3)(ii)(A).

■ e. Redesignate paragraph (b)(5)(i) as (b)(5)(i)(A).

■ f. In newly redesignated paragraph (b)(5)(i)(A), the phrase "on or after December 21, 2000," is removed and the phrase "on or after December 21, 2000 and on or before December 31, 2003," is added in its place.

■ g. Add a new paragraph (b)(5)(i)(B).

The revision and addition 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. However, for cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its previous election, the CAH must submit a termination request to the fiscal intermediary or MAC servicing the CAH prior to December 1, 2010. If a CAH had no election in effect in its most recent preceding cost reporting period and chooses to elect the method specified in paragraph (b)(3)(i) of this section 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.

(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.

(ii) * * *

(A) Effective for cost reporting periods beginning on or after January 1, 2004, for facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

* * * * *

(5) * * *

(i) * * *

(B) Effective for cost reporting periods beginning on or after January 1, 2004, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

* * * * *

■ 33. Section 413.75(b) is amended by revising the definitions of "Primary care resident", and "Resident" 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.

* * * * *

■ 34. Section 413.85 is amended by—

■ a. Revising paragraph (c)(2).

■ b. Revising paragraph (d)(1)(i)(C).

The revisions read as follows:

§ 413.85 Cost of approved nursing and allied health education activities.

* * * * *

(c) * * *

(2) Enhance the quality of health care at the provider; and

* * * * *

(d) * * *

(1) * * *

(i) * * *

(C) Enhance the quality of health care at the provider.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

■ 35. The authority citation for Part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 36. In § 415.152, the definition of "Approved graduate medical education" is amended by revising paragraph (1) to read as follows:

§ 415.152 Definitions.

* * * * *

Approved graduate medical education program means one of the following:

(1) A residency program approved by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 37. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.510 [Amended]

■ 38. In 424.510, paragraph (c), remove the reference "§ 489.13(d)" and add the reference "§ 489.13" in its place.

§ 424.520 [Amended]

■ 39. In 424.520, paragraph (a), remove the reference "§ 489.13(d)" and add the reference "§ 489.13" in its place.

PART 440—SERVICES: GENERAL PROVISIONS

■ 40. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 41. Section 440.160 is amended by revising paragraph (b)(1) to read as follows:

§ 440.160 Inpatient psychiatric services for individuals under age 21.

* * * * *

(b) * * *

(1) A psychiatric hospital that undergoes a State survey to determine whether the hospital 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 undergoes a State survey to determine whether the hospital 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.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

■ 42. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 43. Section 441.151 is amended by revising paragraph (a)(2)(i) to read as follows:

§ 441.151 General requirements.

(a) * * *

(2) * * *

(i) A psychiatric hospital that undergoes a State survey to determine whether the hospital 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 undergoes a State survey to determine whether the hospital 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.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

■ 44. 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)).

■ 45. 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 in accordance with 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.

■ 46. Section 482.57 is amended by revising paragraph (b)(3) and by 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 in accordance with the requirements at § 482.24.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 47. 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)).

■ 48. 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

■ 49. 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).

■ 50. 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.

■ 52. 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 surveyors; or

(ii) In lieu of such State survey agency or CMS conducted survey, accreditation by an accreditation organization whose program has CMS approval in accordance with section 1865 of the Act 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, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the effective 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. However, if other Federal requirements remain to be satisfied, notwithstanding the provisions of paragraphs (c)(1) through (c)(3) of this section, 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.

(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).

(3) 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: July 23, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 28, 2010

Kathleen Sebelius,

Secretary.

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

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

I. Summary and Background

Several provisions of the Affordable Care Act affect the hospital inpatient update for both FYs 2010 and 2011. However, due to the timing of the passage of the legislation, we were unable to address those provisions in the FY 2011 IPPS/LTCH PPS proposed rule issued in the **Federal Register** on May 4, 2010 (75 FR 23852). On June 2, 2010, we issued a supplemental proposed rule to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30756) to address these provisions. The discussion below reflects both the provisions of the initial FY 2011 proposed rule and the supplemental proposed rule relative to the FY 2011 payment rates and factors and any public comments that we received on both documents.

In this Addendum, we are setting forth a description of the methods and data we used to determine the prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs for FY 2011 for acute care hospitals. In this final rule, we also are setting forth the final 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 final rule, we are finalizing 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 final 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. Section 3124(a) of the Affordable Care Act amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act to extend the MDH program and payment methodology from the end of FY 2011 to the end of FY 2012, by striking "October 1, 2011" and inserting "October 1, 2012". Section 3124(b) of the Affordable Care Act also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. Section 3124(b)(2) of the Affordable Care Act also amended section 13501(e)(2) of OBRA 1993 to extend the provision permitting hospitals to decline reclassification as an MDH through FY 2012. In section IV.G.2. of the preamble to this final rule, we are adopting as final the proposed changes to § 412.108(a)(1) and (c)(2)(iii) to reflect the legislative extension of the MDH program for an additional year, through FY 2012. Under section 5003(b) of Pub. L. 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 making 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 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 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 making 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 final rule are presented in section VI. of this Addendum.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 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 prospective payment rates for FY 2011.

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

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act.
- The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act.
- Updates of 2.35 percent for all areas (that is, the estimated full market basket percentage increase of 2.6 percent minus 0.25 percentage points), as required by section 1886(b)(3)(B)(i) of the Act, as amended by sections 3401(a) and10319(a) of the Affordable Care Act, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner, and at the time specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- An update of 2.35 percent to the Puerto Rico-specific standardized amount (that is, the estimated full market basket percentage increase of 2.6 percent minus 0.25 percentage point), as finalized in the preamble of this final rule 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 ensure the effects of the rural community hospital demonstration required under section 410A of Public Law 108–173 as amended by sections 3123 and 10313 of Public Law 111–148 which extends the demonstration for an additional 5 years are budget neutral, as required under section 410A (c)(2) of Public Law 108–173.
- 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 final 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 the effect of documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009.

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 continuing to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amount, for FY 2011, we are continuing to apply the imputed floor budget neutrality adjustment to the wage indices. For this final rule, consistent with section 3141 of the Affordable Care Act, instead of applying a State level rural floor budget neutrality adjustment on the wage index, we are restoring the budget neutrality adjustment for the rural and imputed floors to a uniform, national adjustment, beginning with the FY 2011 wage index.

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 continuing 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 standardized amounts for operating costs appear in Table 1A, 1B, and 1C of the Addendum to this final rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are calculating the FY 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(b)(3)(B)(i) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act, we are updating the standardized amount for FY 2011 by the estimated market basket percentage increase minus 0.25 percentage points for hospitals in all areas. Section 3401(a)(4) of Pub. L. 111–148 further states that this amendment may result in the applicable percentage increase being less than zero. 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. Based on IHS Global Insight, Inc.'s 2010 second quarter forecast of the hospital market basket increase (as discussed in Appendix B of this final rule), the most recent forecast of the hospital market basket increase for FY 2011 is 2.6 percent. Thus, for FY 2011, the update to the average standardized amount is 2.35 percent for hospitals in all areas (that is, the estimated full market basket percentage increase of 2.6 percent minus 0.25 percentage point).

Section 1886(b)(3)(B) of the Act specifies the applicable percentage increase 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 applicable percentage increase (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. Thus, for hospitals that do not submit quality data, the estimated update to the operating standardized amount is 0.35 percent (that is, the adjusted FY 2011 estimate of the market basket rate-of-increase of 2.35 percent minus 2.0 percentage points). The standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas. As finalized in the preamble to this final rule, we are applying the full rate-of-increase in the hospital market basket minus 0.25 percentage point to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is also 2.35 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 final rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting 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 final rule, we identified Medicare Advantage claims from IPPS teaching hospitals in the MedPAR data. The GHO Paid indicator with a value of "1" on the MedPAR file indicates that the claim was paid by a Medicare Advantage plan (other than the IPPS IME payment specified at § 412.105(g)). We note that we also modified our method for identifying MA claims from IPPS teaching hospitals in the MedPAR data pursuant to public comment. We describe this modification below in our response to that comment. 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.

Comment: Commenters noted that it appeared CMS had inadvertently included approximately 74,000 MA claims submitted by teaching hospitals as regular IPPS claims instead of identifying these claims as MA claims. The commenter explained that these

claims lacked an "HMO Paid" designation but the only payment made on the claim was the IME payment. Therefore, in the commenters opinion these claims should have been considered MA IME claims for the purpose of our calculations.

Response: We examined the MedPAR file and have determined that there are claims that do not have a GHO Paid indicator with a value of "1" but the IME payment field is equal to the DRG payment field. We agree with the commenter and included these claims in our determination of the total Medicare Advantage IME payment amount. Specifically, we first searched the MedPAR file for all claims with an IME payment greater than zero. We then filtered these claims for a subset of claims with a GHO Paid indicator with a value of "1" or with the IME payment field equal to the DRG payment field. As mentioned above, we then added the total Medicare Advantage IME payment amount 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.

Comment: Commenters also noted that it is likely that CMS included charges for anti hemophilic blood factor for the budget neutrality adjustments.

Response: With respect to charges for anti hemophilic blood factor, we examined the MedPAR and have removed pharmacy charges with an indicator of '3' for blood clotting with a revenue code of '0636'from the covered charge field. We also removed organ acquisition charges from the covered charge field since organ acquisition is a pass through payment not paid under the IPPS.

We finally note that on June 2, 2010, we issued a notice that contains the final wage indices, hospital reclassifications, payment rates, impacts, and other related tables effective for the FY 2010 IPPS and RY 2010 LTCH PPS. The rates, tables, and impacts included in the FY 2010 IPPS/LTCH PPS notice reflect changes required by or resulting from the implementation of several provisions from the Affordable Care Act. Specifically, sections 3401(a) and 10319(a) of the Affordable Care Act amended section 1886(b)(3)(B)(i) of the Act to set the FY 2010 applicable percentage increase for IPPS hospitals equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas minus a 0.25 percentage point, 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. Section 1886(b)(3)(B)(i) of the Act establishes the applicable percentage increase used for annual updates to the Federal rates. Section 1886(b)(3)(B)(xii)(I) explicitly adjusts the applicable percentage for the FY 2010 Federal rates. Section 3401(p) of the Affordable Care Act provides that, notwithstanding the previous provisions of this section, the amendments made by subsections (a), (c) and (d) shall not apply to discharges occurring before April 1, 2010. When read together, we believe sections 1886(b)(3)(B)(i) and 1886(b)(3)(B)(xii) of the Act and section 3401(p) of the Affordable Care Act provide for revised FY 2010 Federal rates for the entire fiscal year; however, discharges occurring on or after October 1, 2009 and before April 1, 2010, are not paid be based on the updated FY 2010 standard Federal rate. When we refer to FY 2010 payments in the discussion below, these payments are modeled for the entire FY 2010 based on the revised rates consistent with the Affordable Care Act. Also, because there were no updates to the pre-reclassified wage file for FY 2010, when we refer below to the pre-reclassified wage data for FY 2010, this is the same pre reclassified wage data from the FY 2010 IPPS/LTCH PPS final rule.

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

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

Section 1886(d)(3)(E)(i) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. 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 adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.D. of the preamble of this final rule.

For FY 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 FY 2011 relative weights, and the FY 2010 pre-reclassified wage data. Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.996731. As discussed in section IV. of this Addendum, we apply the DRG reclassification and recalibration budget neutrality factor of 0.996731 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2010.

Comment: One commenter commented that CMS' current methodology for reclassifying and recalibrating the DRGs does not comport with the statutory requirement in section 1886(d)(4)(C)(iii) of the Act. The commenter noted that CMS attempts to achieve budget neutrality by calculating a separate, subsequent budget neutrality factor, which it then applies to the standardized amount and the HSP, rather than to the DRG weights. The commenter further noted that CMS has broad discretion in implementing the technical details of the Medicare program, and the commenter understood the rationale for CMS's methodology. However, the commenter maintains that this methodology fails to satisfy the express directive set forth in section 1886(d)(4)(C)(iii) of the Act. The commenter explained that section 1886(d)(4)(C)(iii) of the Act provides that the annual adjustments to DRG classifications and weighting factors must "be made in a manner that assures" budget neutrality. The commenter believes that the statute directs that the budget neutrality adjustment and the reclassifications and recalibrations themselves are the subject of the budget neutrality requirement (instead of applying an adjustment factor to the payment rates). The commenter asserts that this meaning is evident on the face of the statute.

Response: As stated above, 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. In order to ensure budget neutrality, we normalize 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, we make a budget neutrality adjustment to the

payment rates to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met. We believe our methodology of applying the DRG reclassification and recalibration budget neutrality adjustment to the payment rates is the correct interpretation of the statute since this ensures that "aggregate payments to hospitals" are not affected, which is consistent with the statute in section 1886(d)(4)(C)(iii) of the Act.

In order to meet the statutory requirements that we do not take into account the labor-related share of 62 percent when computing wage index budget neutrality, it was necessary to use a three-step process to comply with the requirements that DRG reclassification and recalibration of the relative weights and the updated wage index and labor-related share have no effect on aggregate payments for IPPS hospitals. We first determined a DRG reclassification and recalibration budget neutrality factor of 0.996731 by using the same methodology described above to determine the DRG reclassification and recalibration budget neutrality factor for the Puerto Rico standardized amount and hospital-specific rates. Secondly, to compute a budget neutrality factor for wage index and labor-related share changes, we used FY 2009 discharge data to simulate payments and compared aggregate payments using 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 FY 2011 relative weights and the 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 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 budget neutrality factor of 1.000013 for changes to the wage index. Finally, we multiplied the DRG reclassification and recalibration budget neutrality factor of 0.996731 (derived in the first step) by the budget neutrality factor of 1.000013 for changes to the wage index (derived in the second step) to determine the DRG reclassification and recalibration and updated wage index budget neutrality factor of 0.996744.

b. Reclassified Hospitals—Budget Neutrality Adjustment

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account "in applying any budget neutrality adjustment with respect to such index" under section 1886(d)(8)(D) of the Act. To calculate the budget neutrality factor for FY 2011, we used FY 2009 discharge data to simulate payments and compared total IPPS payments with FY 2011 relative weights, FY 2011 labor share percentages, and 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 FY 2011 relative weights, FY 2011 labor share percentages, and FY 2011 wage data after such reclassifications. Based on these simulations, we calculated an adjustment factor of 0.991264 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The 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 FY 2011 budget neutrality adjustment reflects FY 2011 wage index reclassifications approved by the MGCRB or the Administrator. We note that for this final rule, as discussed in section III.B. of the preamble to this final rule, section 3137(c) of Public Law 111–148 resulted in some additional hospitals receiving reclassifications, or some hospitals receiving reclassifications to a different area. These reclassifications are included in the calculation of reclassification budget neutrality.

c. Rural Floor and Imputed Floor Budget Neutrality Adjustment

We make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the BBA (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) of the regulations are made in a manner that ensures that aggregate payments to hospitals are not affected. 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 the FY 2011 IPPS/LTCH PPS proposed rule, in the absence of provisions of Public Law 111–148, the proposed adjustment would have been completely transitioned to the State level methodology, such that the wage index that was proposed in the FY 2011 IPPS/LTCH PPS proposed rule was determined by applying 100 percent of the State level budget neutrality adjustment. However, section 3141 of Public Law 111–148 restores the budget neutrality adjustment for the rural and imputed floors to a uniform, national adjustment, beginning with the FY 2011 wage index.

Using the same methodology in prior final rules to calculate the national rural and imputed floor budget neutrality adjustment factor (which was part of the methodology to calculate the blended rural and imputed floor budget neutrality adjustment factors), to determine the wage index adjusted by the national rural and imputed floor budget neutrality adjustment, we used FY 2009 discharge data and FY 2011 wage indices to simulate IPPS payments. First, we compared the national simulated payments without the rural and imputed floors applied to national simulated payments with the rural and imputed floors applied to determine the national rural and imputed floor budget neutrality adjustment factor of 0.996641. This national adjustment was then applied to the wage indices to produce a national rural and imputed floor budget neutral wage index.

d. 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 Pub. L. 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.4 in the preamble to this final 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. We note that there may be a need to actuarially adjust the recoupment adjustment in FY 2012 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 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 final 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 making an adjustment in FY 2011 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 establishing an adjustment for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in this final rule.

(2) Adjustment to the FY 2011 Hospital-Specific Rates for SCHs and MDHs

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

As discussed in the 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 final 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 of 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 final 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. Consequently, in order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals, we are making an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. We believe that this 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) Adjustment to the FY 2011 Puerto Rico Standardized Amount

As stated in section II.D. of the preamble of this final rule, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the

Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. In the 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 could 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 final rule, our best estimate, based on the most recently available data, is that a cumulative adjustment of −2.6 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 −2.6 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 making an adjustment of −2.6 percent in FY 2011 to the Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount, which we are adjusting 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 −2.6 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 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. Rural Community Hospital Demonstration Program Adjustment

As discussed in section IV.K. of the preamble to this final rule, section 410A of Public Law 108–173 originally required the Secretary to establish a demonstration that modifes reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Public Law 108–173 requires that "[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." In the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, although we proposed to apply an adjustment to the IPPS rates to account for the amount by which the costs of the demonstration as indicated by the 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 IPPS final rule as the budget neutrality offset for 2007, we were unable to calculate a numeric adjustment to the standardized amount to ensure the effects of the rural community hospital demonstration are budget neutral. This is because we were waiting for settled cost reports. In addition, we noted that the proposed rule did not account for changes to the demonstration required by the Affordable Care Act. Specifically, among other things, sections 3123 and 10313 of the Affordable Care Act extended the demonstration for an additional 5 year period, and allow not more than 30 hospitals to participate in 20 States with low population densities determined by the Secretary. (In determining which States to include in the expansion, the Secretary is required to use the same criteria and data that the Secretary used to determine the States for purposes of the initial 5-year period.) In the FY 2011 IPPS/LTCH PPS supplemental proposed rule, we proposed to adjust the IPPS rate by an amount sufficient to account for the added costs of this demonstration. We proposed an adjustment factor to account for the added costs associated with the demonstration for certain time periods as a result of the Affordable Care Act, as explained at 75 FR 30961 through 30965, as well as proposed to offset the IPPS standardized rate for the added costs of the demonstration in FY 2007, although we were unable to propose a specific numeric adjustment to correspond to FY 2007 in the supplemental proposed rule.

In order to achieve budget neutrality, as proposed (except as indicated later in this section and elsewhere in the preamble of this final rule), we are making an adjustment to the national IPPS rates by an amount sufficient to account for the added costs of this demonstration as described in section IV.K of this final rule. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, consistent with past practice. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that "aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented," but does not identify the range across which aggregate payments must be held equal. As mentioned in section IV.K of the preamble to this final rule, the estimated amount for the adjustment to the national IPPS rates for FY 2011 is $70,483,384. Accordingly, to account for the changes to the demonstration required by the Affordable Care Act for specific time periods as explained in detail in section IV.K of this final rule, for FY 2011 we computed a factor of 0.999302 for the rural community hospital demonstration program adjustment that will be applied to the IPPS standardized rate. We note that because the settlement process for the demonstration hospitals' third year cost reports, that is, for cost reporting periods starting in FY 2007, has experienced a delay, for the FY 2011 IPPS/LTCH PPS proposed rule and the supplemental proposed rule, we were unable to state the costs of the demonstration corresponding to FY 2007 and as a result were unable to propose the specific numeric adjustment representing this offsetting process that would be applied to the national IPPS rates. Due to operational issues in the cost report settlement process, settled cost reports for the hospitals that participated in the demonstration in FY 2007 are not available in time for this final rule either although we expected them to be available. Therefore, the estimated adjustment to the national IPPS rate in this final rule cannot include a component to account for these costs. We anticipate that this information may be available for the FY 2012 IPPS/LTCH PPS proposed rule, at which time we would include a similar proposal.

f. 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) FY 2011 Outlier Fixed-Loss Cost Threshold

The FY 2011 IPPS/LTCH PPS supplemental proposed rule contained a summary of the provisions from the Affordable Care Act that affected the initial FY 2011 proposed outlier threshold and then specified our proposed revised FY 2011 outlier threshold (74 FR 30975). The revised FY 2011 proposed outlier threshold used the same methodology as the initial FY 2011 proposed outlier threshold but did not repeat the entire methodology that was discussed in the FY 2011 IPPS/LTCH PPS proposed rule (74 FR 24068 through 24069). Below we discuss in full the methodology used to compute the revised FY 2011 proposed outlier threshold.

For FY 2011, we proposed to continue to use the same methodology used for FY 2009 (73 FR 48763 through 48766) to calculate the outlier threshold. Similar to the methodology used in the FY 2009 IPPS final rule, for FY 2011, we proposed to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2011 outlier threshold, we simulated payments by applying 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 proposed to continue to use a refined methodology that takes into account the lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2008 in combination with the first quarter of FY 2009 (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 the proposed rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 IPPS final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2011, we proposed 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 update 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 (1.040). 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 1.040, 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 1.036). 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 proposed 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. As discussed in section II.A. of the preamble to the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30975), in accordance with section 10324(a) of Public Law 111–148, beginning in FY 2011, we created a wage index floor of 1.00 for all hospitals located in States determined to be frontier States. We noted that the frontier State floor adjustments will be calculated and applied after rural and imputed floor budget neutrality adjustments are calculated for all labor market areas, so as to ensure that no hospital in a frontier State will receive a wage index lesser than 1.00 due to the rural and imputed floor adjustment. In accordance with section 10324(a) of the Affordable Care Act, the frontier State adjustment will not be subject to budget neutrality, and will only be extended to hospitals geographically located within a frontier State. However, for purposes of estimating the proposed outlier threshold for FY 2011, it was necessary to apply this provision by adjusting the wage index of those eligible hospitals in a Frontier State when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2011. If we did not take into account this provision, our estimate of total FY 2011 payments would be too low, and as a result, our proposed outlier threshold would be too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments.

Also, 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 the proposed rule, we used 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 estimated that there would 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, in the supplemental proposed rule, we proposed 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 $24,165.

As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2011 outlier payments, we did not propose 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 proposed not to make any assumptions about the effects of reconciliation on the outlier threshold calculation.

Comment: Many commenters, including major hospital associations, noted that CMS currently estimates outlier payments in FY 2010 at 4.7 percent of total payments. The commenters commended CMS for making refinements such as applying an adjustment factor to CCRs when computing the outlier threshold but noted that, because CMS is still not reaching the 5.1 percent target, there is still room for improvement. The commenters further stated that although CMS currently projects outlier payments in FY 2010 to be estimated at 4.7 percent of total payments, which is lower than the 5.1 percent target, this estimate is based on discharges from a prior year (2009) and will likely not reflect the actual result. The commenters noted that in prior years when CMS provided its projected estimate of outlier payments for a given fiscal year, once the actual claims were available to determine the actual outlier payment (in the following fiscal year), the estimate declined between 0.2 percent and 0.3 percent from the projection.

The commenters also suggested that the methodology developed by the CMS Office of the Actuary to determine a cost adjustment factor to the CCRs (which is then divided by the charge adjustment factor) is unnecessarily complicated and does not lead to a more accurate result. The commenters urged CMS to adopt a methodology that uses recent historical industry wide average rate of change, similar to the methodology used to develop the charge inflation factor. Further, in addition to recommending that CMS apply a cost adjustment to the CCRs based on historical data, the commenters suggested that the charge adjustment to the CCRs be projected over different periods of time, some less or more than one year, based on variations in hospital fiscal year ends. The commenters opposed CMS's use of the December 2009 update of the PSF without projecting CCRs over different periods of time for purposes of estimating FY 2010 outlier payments and asserted that CMS's methodology is oversimplified. The commenters believed that their methodology would more accurately project the decline in CCRs.

The commenters also suggested that if CMS did not incorporate their recommended changes to the methodology for estimating outlier payments, that they would recommend incorporating an "estimate adjustment factor" into the outlier projections. The commenters explained that outlier payments have been underpaid in every year since 2004. Based on actual payments, the commenters estimate that underpayment has exceeded 0.24 percent in all years. The commenters recommended that CMS maintain the outlier threshold at 5.1 percent but should apply an estimate adjustment factor when projecting the outlier threshold. The commenters provided an example and computed this factor for FY 2008 and FY 2009 by taking the average variance in the actual payment (from the annual estimate of maintaining outliers at 5.1 percent) for FY 2008 and FY 2009 which was 0.385 percent. Based on this factor, the commenters suggest CMS would model the threshold to a level of 5.485 percent (5.1 plus .385 percent). If CMS were to overpay outliers in a specific year, then the adjustment would be become negative. The commenters stated that this would fulfill the statutory requirement in section 1886(d)(5)(A) of the Act that requires that CMS establish thresholds such that outlier payments will be projected to achieve at least 5.1 percent of DRG payments and would more closely achieve a result that is fully consistent with the statute.

Response: Commenters to previous rules have raised similar concerns regarding our estimates of outlier payments. We refer readers to a similar discussion in the FY 2008 final rule (72 FR 47418). As we have mentioned in the past, in response to the comment that CCRs should be projected over different periods of time, it is possible that some of the CCRs in the March PSF will be used in FY 2009 for actual outlier payments, while other CCRs may be one year old. Therefore, we apply a 1-year adjustment to

the CCRs. With respect to the comment on our methodology used to adjust the CCRs, as we stated in the FY 2008 IPPS final rule with comment period (72 FR 47418), we continue to believe this calculation of an adjustment to the CCRs is more accurate and stable than the commenter's methodology because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor. There are times where the market basket and the cost per discharge will be constant, while other times these values will differ from each other, depending on the fiscal year. Therefore, as mentioned above, using the market basket in conjunction with the cost per discharge takes into account two sources that measure potential cost inflation and ensures a more accurate and stable cost adjustment factor. Therefore, we continue to believe that our methodology for adjusting the cost-to-charge ratios is an appropriate method for use in determining the outlier threshold. We also note that with respect to FY 2009 calculations, we are currently projecting FY 2009 payments at an estimate of 5.4 percent of overall payments. The commenter noted that once actual data is available to determine the outlier payment, the outlier estimate tends to decline by 0.2 percent or 0.3 percent. If this trend stays constant, it appears the FY 2009 threshold would result in an outlier payout very close to 5.1 percent according to the commenters.

With respect to the comment of computing an "estimate adjustment factor", our outlier policy is intended to reimburse hospitals for treating extraordinarily costly cases and, under the statute, outlier payments are intended to approximate the marginal cost of providing care above the outlier fixed-loss cost threshold. Any "estimate adjustment factor" to the outlier threshold or standardized amount in a given year to account for "overpayments" or "underpayments" of outliers in other years would result in us making outlier payments that were not directly related to the cost of furnishing care in extraordinarily costly cases. Additionally, when we conduct our modeling to determine the outlier threshold, we factor all in all payments and policies that would affect actual payments for the fiscal year at hand (as discussed above, including the frontier wage index for FY 2011 and the cumulative effect of documentation and coding that has occurred that is already reflected within the FY 2009 MedPAR claims data) in order to ensure accuracy when determining outlier payments that are 5.1 percent of total DRG payments. Including an "estimate adjustment factor" that is not relative to the current fiscal year does not lend greater accuracy to the estimate of payments that are 5.1 percent of total DRG payments. Finally, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments in a past year are equal to 5.1 percent of total DRG payments. In short, we believe our outlier policies are consistent with the statute and the goals of the prospective payment system.

Comment: One commenter was concerned that CMS did not include outlier reconciliations in developing the outlier threshold. The commenter requested that CMS disclose in the final rule and future proposed and final IPPS rules the amount of money it has recovered through reconciliation. The commenter explained that this information will allow others to comment specifically on how this provision would impact the threshold.

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

Comment: Commenters noted that it appears CMS has inadvertently included approximately 74,000 MA claims submitted by teaching hospitals, which appear in the MedPAR file when hospitals submit no-pay bills for purposes of IME payment. The commenter explained that these claims lacked an "HMO Paid" designation but the only payment made on the claim was the IME payment. The commenter recommended that CMS exclude these claims from the outlier threshold calculation since they are not paid under the IPPS.

Commenters also noted that it is likely that CMS included charges for anti hemophilic blood factor, which are paid separately under the IPPS. The commenter further noted that in the FY 2010 IPPS/LTCH PPS final rule, CMS agreed that the clotting factor issue was a problem and CMS stated it would seek a solution in future years. The commenter requested that CMS disclose if a solution has been determined.

Response: We examined the MedPAR file and have determined that there are claims that do not have a GHO Paid indicator with a value of "1" but the IME payment field is equal to the DRG payment field. We agree with the commenter and have excluded claims from the outlier calculation that have a GHO Paid indicator with a value of "1" or do not have a GHO Paid indicator with a value of "1" but do have an IMEPAY filed equal to the DRGPAY field since these are probably MA claims that are likely not paid under the IPPS and therefore would not incur an outlier payment.

With respect to charges for anti hemophilic blood factor, we examined the MedPAR and have removed pharmacy charges with an indicator of "3" for blood clotting with a revenue code of "0636"from the covered charge field. We also removed organ acquisition charges from the covered charge field since organ acquisition is a pass through payment not paid under the IPPS.

Because we are not making any changes to our methodology for this final rule, for FY 2011, we are using the same methodology we proposed to calculate the outlier threshold.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the first quarter of FY 2009 in combination with the second quarter of FY 2009 (October 1, 2008 through March 31, 2009) to the first quarter of FY 2010 in combination with the second quarter of FY 2010 (October 1, 2009 through March 31, 2010). This rate of change was 4.8257 percent (1.048257) or 9.8843 percent (1.098843) over 2 years.

As we have done in the past, we established the final FY 2011 outlier threshold using hospital CCRs from the March 2010 update to the Provider-Specific File (PSF)—the most recent available data at the time of this final 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).

For FY 2010, we calculated the CCR adjustment by using the 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 update 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 (1.0511) from the cost report and dividing it by the final operating market basket percentage increase from FY 2008 (1.040). 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 1.0574 divided by the FY 2006 final operating market basket percentage increase of 1.040, the FY 2006 to FY 2007 percentage increase of operating costs per discharge of 1.0464 divided by FY 2007 final operating market basket percentage increase of 1.036). For FY 2011, we averaged the differentials calculated for FY 2006, FY 2007, and FY 2008, which resulted in a mean ratio of 1.0125. We multiplied the 3-year average of 1.0125 by the FY 2009 final operating market basket percentage increase of 1.026, which resulted in an operating cost inflation factor of 3.88 percent or 1.0388. We then divided the operating cost inflation factor by the 1-year average change in charges (1.048257) and applied an adjustment factor of 0.990983 to the operating CCRs from the PSF (calculation performed on unrounded numbers).

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 (1.0813) 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 1.0470 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 1.0504 divided by the FY 2007 final capital market basket percentage increase of 1.013). 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 (1.048257) and applied an adjustment factor of 1.011768 to the capital CCRs from the PSF (calculation performed on unrounded numbers). We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2011, we applied the FY 2011 rates and policies using cases from the FY 2009 MedPAR files in calculating the final outlier threshold. As discussed in section II.B.3. of the preamble to this final rule, in accordance with section 10324(a) of Public Law 111–148, beginning in FY 2011, we created a wage index floor of 1.00 for all hospitals located in States determined to be Frontier States. We noted that the Frontier State floor adjustments will be calculated and applied after rural and imputed floor budget neutrality adjustments are calculated for all labor market areas, so as to ensure that no hospital in a Frontier State will receive a wage index lesser than 1.00 due to the rural and imputed floor adjustment. In accordance with section 10324(a) of the Affordable Care Act, the frontier State adjustment will not be subject to budget neutrality, and will only be extended to hospitals geographically located within a frontier State. However, for purposes of estimating the final outlier threshold for FY 2011, it was necessary to apply this provision by adjusting the wage index of those eligible hospitals in a Frontier State when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2011. If we did not take into account this provision, our estimate of total FY 2011 payments would be too low, and as a result, our final outlier threshold would be too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments.

Also, in FY 2010, for purposes of estimating the final 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 the final rule, we used the FY 2009 claims data to calculate the FY 2011 final 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 final FY 2011 outlier threshold. Furthermore, we estimate that there would 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 calculated a final 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 $23,075.

We note that the final threshold is lower than the proposed outlier threshold in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (and is similar to the estimate of the outlier threshold calculated by the commenters above). We believe that the increase in the market basket from 2.15 percent in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (that is, the estimated full market basket percentage increase of 2.4 percent minus 0.25 percentage point) to 2.35 percent for this final rule (that is, the estimated full market basket percentage increase of 2.6 percent minus 0.25 percentage point) contributed to a lower final fixed loss outlier threshold for FY 2011. Specifically, adding an extra 0.2 percent to the standardized amount increases funds to typical cases and requires that we lower the outlier threshold to increase the amount of atypical cases in order to reach the 5.1 percent target.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2011 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.96 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 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 based on the FY 2011 outlier threshold are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948999	0.940415
Puerto Rico	0.948079	0.918951

We are applying apply the outlier adjustment factors to the 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 1.175 or capital CCRs greater than 0.159, or hospitals for which the fiscal intermediary or MAC is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations), we use statewide average CCRs to determine whether a hospital qualifies for outlier payments.[21] Table 8A in this Addendum contains the statewide average operating CCRs for urban hospitals and for rural

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

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 comparable statewide average capital CCRs. Again, the 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 statewide average total 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 for 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 when setting the outlier policies for FY 2010. This estimate of 4.7 percent is based on simulations using the FY 2009 MedPAR file (discharge data for FY 2009 claims).

Comment: Commenters requested that CMS clarify and review how the actual outlier payments for FY 2009, as reported in the proposed rule, were calculated. The commenters noted that in the proposed rule, CMS indicated that the actual outlier payments for FY 2009 will be 5.3 percent of actual DRG payments. However, the commenter performed their own analysis using payment information in the MedPAR and concluded that actual outlier payments for FY 2009 would be 4.9 percent of actual DRG payments. The commenter recommended that CMS determine the FY 2009 outlier payment percentage using a data element that they asserted represented actual payments rather than using a modeled estimate of actual payments. The commenter also noted that, while they differed on the FY 2009 estimate, they were able to match the FY 2010 and FY 2011 outlier percentages we published in the proposed rule.

Response: We believe that modeling the estimated actual payments for FY 2009 is a reasonable approach to approximating the outlier payment percentage for FY 2009. In modeling the FY 2009 payments we use the same programming approach used in determining the FY 2010 and FY 2011 outlier payment percentages. We continue to believe that our modeling approach is sound; we note that the commenters were able to match our published percentages for FY 2010 and 2011 using their own models,. In calculating the estimated FY 2009 outlier payment percentage we use the FY 2009 payment rates, rules and factors and the latest update of the FY 2009 MedPAR file. This is consistent with our approach for the rate setting for FY 2011 (which also models the FY 2010 payments for use in the FY 2011 rate setting). Although the MedPAR file contains a field labeled the DRG PRICE that represents the actual amounts paid to hospitals by claim, we believe that modeling enhances the completeness and the accuracy of our estimates of actual payments. While accurate at the time the MedPAR file is constructed, claims can be cancelled, edited and resubmitted to NCH after the MedPAR file is built, and therefore the payment field shown on MedPAR is subject to change and does not necessarily represent the final payment on that claim. Additionally, various payment exceptions under the IPPS such as the hospital specific rate payment adjustment for Sole Community Hospitals and Medicare Dependant Hospitals complicate the use of the payment field shown on the MedPAR file. PRICER, the IPPS payment software, calculates payments on a claim by claim basis and consequently claims may be paid on either the federal rate or the hospital specific rate depending on which produces a greater payment; the payments to these hospitals are not finalized until the cost report settlement and at that time must either be based on one hundred percent of either the hospital specific amount or the federal amount. Due to these additional concerns, the DRG PRICE field would also only generate an estimate, rather than an actual, amount of outlier payments. For these reasons, we continue to believe that modeling is an acceptable and accurate approach to estimating the outlier payment percentage in a given year. We also note that our model has been replicated by the commenters.

5. FY 2011 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2011. The Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the 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 the standardized amounts reflecting the applicable percentage increase of 2.35 percent update for FY 2011, and standardized amounts reflecting the 2.0 percentage point reduction to that update (a 0.35 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this amount is set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2011 are set forth in Table 1C of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico specific standardized amount is the labor-related share of 62.1 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of 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 changes from the FY 2010 national standardized amount. The second column shows the changes from the FY 2010 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the update of 2.35 percent. The third column shows the changes for hospitals receiving the reduced update of 0.35 percent. The first row of the table shows the 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.

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COMPARISON OF FY 2010 STANDARDIZED AMOUNTS TO THE 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: $3,869.62 Nonlabor: $1,754.83	Labor: $3,487.15 Nonlabor: $2,137.29	Labor: $3,869.62 Nonlabor: $1,754.83	Labor: $3,487.15 Nonlabor: $2,137.29
FY 2011 Update Factor	1.0235	1.0235	1.0035	1.0035
FY 2011 DRG Recalibration and Wage Index Budget Neutrality Factor	0.996744	0.996744	0.996744	0.996744
FY 2011 Reclassification Budget Neutrality Factor	0.991264	0.991264	0.991264	0.991264
FY 2011 Rural Demonstration Budget Neutrality Factor	0.999302	0.999302	0.999302	0.999302
FY 2011 Outlier Factor	0.948999	0.948999	0.948999	0.948999
Cumulative Documentation and Coding Adjustment	0.9574	0.9574	0.9574	0.9574
Rate for FY 2011	Labor: $3,552.91 Nonlabor: $1,611.20	Labor: $3,201.75 Nonlabor:$1,962.36	Labor: $3,483.49 Nonlabor: $1,579.72	Labor: $3,139.19 Nonlabor: $1,924.02

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B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2011. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2011 wage index.

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

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2011, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below. These factors were obtained from the U.S. Office of Personnel Management (OPM) and are the same as the factors currently in use under the IPPS for FY 2010.

Table of Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

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

C. MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this final rule, we have developed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the relative weights that we are applying to discharges occurring in FY 2011. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 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 effective is adjusted by the DRG reclassification and recalibration budget neutrality factor of 0.996731 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

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase applicable to the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase 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). Because the Act sets the update factor for SCHs and MDHs equal to the update factor for all other IPPS hospitals,

the update to the hospital specific rates for SCHs and MDHs is subject to the amendments to section 1886(b)(3)(B)(i) of the Act made by section 3401(a) of the Affordable Care Act. Accordingly, the applicable percentage increase to the hospital-specific rates applicable to SCHs and MDHs is 2.35 percent (that is, the FY 2011 estimate of the market basket rate-of-increase of 2.6 percent minus 0.25 percentage points) for hospitals that submit quality data or 0.35 percent (that is, the FY 2011 applicable percentage increase of 2.35 percent minus 2.0 percentage points) for hospitals that fail to submit 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. 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 used to determine the capital Federal rate for FY 2011, which will 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 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 a capital Federal rate of $429.26 for FY 2010. However, as discussed earlier in this final rule, in the June 2, 2010 **Federal Register**, we announced the revised policies and payment rates for FY 2010 under the IPPS that reflected the provisions of the Affordable Care Act. Specifically, in the FY 2010 IPPS/RY 2010 LTCH PPS final notice (75 FR 31127), we established a capital Federal rate of $429.56 for FY 2010. For comparison purposes, the payment rates and factors in this section are based on the revised FY 2010 rates and factors announced in that final notice published in **Federal Register** on June 2, 2010.

As also discussed previously in this final rule, several provisions of the Affordable Care Act affected our proposed IPPS policies and payment rates for FY 2011. However, due to the timing of the passage of that legislation we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, and the proposed policies and payment rates in that proposed rule did not reflect the new legislation. Although the provisions of the Affordable Care Act do not directly affect capital IPPS payment rates and factors, we revised our proposed FY 2011 capital rates and factors in the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30977 through 30972) due to the effect of certain provisions of the Affordable Care Act.

In the discussion that follows, we explain the factors that we used to determine the capital Federal rate for FY 2011. In particular, we explain why the FY 2011 capital Federal rate will decrease approximately 2.27 percent, compared to the FY 2010 capital Federal rate. As discussed in the impact analysis in Appendix A of this final rule, we estimate that capital payments per discharge will decrease 0.5 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.

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 update factor for FY 2011 under that framework is 1.5 percent based on the best data available at this time. The 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 final rule, we applied 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 applied 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 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 update for FY 2011. To adjust for reclassification and recalibration effects, under our historical methodology, we ran the FY 2009 cases through the FY 2008 GROUPER and through the FY 2009 GROUPER. The resulting ratio of the case-mix indices equated to 1.0. If the resulting ratio of the case-mix indices had not equated to 1.0 under our historical methodology, in the update framework for FY 2011 we would have made 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 final 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 final rule, we made an adjustment to the capital Federal rate for 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, as we proposed, we did not adjust for reclassification and

recalibration effects from FY 2009 in the update framework for FY 2011 because it is already accounted for in the documentation and coding adjustment to the capital Federal rates for FY 2011. Consequently, there is a 0.0 percent adjustment for DRG reclassification and recalibration in the 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 points 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 points. 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 made 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 non-cost-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 a 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, as we proposed, we used 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, 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 intensity adjustment for FY 2011, and as we proposed, we 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 based the intensity measure on a 5-year average. Therefore, the 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 estimated 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 estimated that intensity declined during that 5-year period, we believe that it is appropriate to continue to apply a zero intensity adjustment for FY 2011. Therefore, we made 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 1.5 percent capital update factor under the capital update framework for FY 2011 as shown in the table below.

CMS FY 2011 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.2

CMS FY 2011 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE—Continued

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. 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 5.22 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 will equal 5.96 percent for inpatient capital-related payments based on the capital Federal rate in FY 2011. Therefore, we applied an outlier adjustment factor of 0.9404 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 final 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 FY 2011 outlier adjustment of 0.9404 is a −0.78 percent change from the FY 2010 outlier adjustment of 0.9478. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2011 is 0.9922 (0.9404/0.9478). Thus, the outlier adjustment decreases the FY 2011 capital Federal rate by 0.78 percent compared with the FY 2010 outlier adjustment.

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

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

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

To determine the factors for FY 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 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 applied an incremental budget neutrality adjustment of 0.9999 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9911, yielding an adjustment of 0.9910, through FY 2011 (calculated with unrounded numbers). For the Puerto Rico GAFs, we applied an incremental budget neutrality adjustment of 1.0005 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9969, yielding a cumulative adjustment of 0.9974 through FY 2011.

We then compared estimated aggregate capital Federal rate payments based on the FY 2010 DRG relative weights and the FY 2011 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2011 MS–DRG classifications and relative weights and the FY 2011 GAFs. The incremental adjustment for DRG classifications and changes in relative weights is 0.9991 both nationally and for Puerto Rico. The cumulative adjustments for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2011 are 0.9902 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]	0.99989	0.99945	0.99941	0.99112	1.00141	0.99953	1.00094	0.99688
2011[17]	.99989	0.99914	0.99903	0.99016	1.00050	0.99914	0.999564	0.99652

[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 revised factors for FY 2010 which reflect the effect of the provisions of the Affordable Care Act.
[17] Final factors for FY 2011

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The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) 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 GAF/DRG 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 revised final GAF/DRG budget neutrality factor of 0.9994 (75 FR 31125). For FY 2011, we established a GAF/DRG budget neutrality factor of 0.9990. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the adjustment from FY 2010 to FY 2011 is 0.9990. The cumulative change in the capital Federal rate due to this adjustment is 0.9902 (the product of the incremental factors for FYs 1995 though 2010 and the incremental factor of 0.9990 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 0.9902 for FY 2011.)

The factor accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 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 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 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 covering 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 covering FY 2008 from the March 2010 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 covering FY 2008, this ratio rounds to 0.0004, and we made an adjustment of 0.0004. Because special exceptions are budget neutral, we offset the capital Federal rate by 0.04 percent for special exceptions payments for FY 2011. Therefore, the exceptions adjustment factor is equal to 0.9996 (1 − 0.0004) to account for special exceptions payments in FY 2011.

In the FY 2010 IPPS/RY 2010 LTCH PPS 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 applied an exceptions payment adjustment factor of 0.9996 (1 − 0.0004) to the capital Federal rate for FY 2011 based on our estimate that exceptions payments in FY 2011 would equal 0.04 percent of aggregate payments based on the FY 2011 capital Federal rate. The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the FY 2011 capital Federal rate is 0.9998 (0.9996/0.9998).

5. Capital Standard Federal Rate for FY 2011

For FY 2010, we established a final capital Federal rate of $429.56. Consistent with section 3401(p) of Public Law 111–148, this rate is applicable to discharges occurring on or after April 1, 2010 (75 FR 31127). We established an update of 1.5 percent in determining the FY 2011 capital Federal rate for all hospitals. However, as discussed in greater detail in section V.E. of the preamble of this final rule, under the statutory authority at section 1886(g) of the Act, consistent with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are making an additional 2.9 percent reduction to the national capital Federal payment rate in FY 2011. The −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 applied a cumulative documentation and coding adjustment factor of 0.9574 in determining the FY 2011 capital Federal rate (that is, the existing −0.6 percent adjustment in FY 2008 plus the −0.9 percent adjustment in FY 2009 plus the 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 1.5 percent update and other budget neutrality factors discussed above, we established a national capital Federal rate of $420.01 for FY 2011. The national capital Federal rate for FY 2011 was calculated as follows:

- The FY 2011 update factor is 1.015, that is, the update is 1.5 percent.
- The FY 2011 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9990.
- The FY 2011 outlier adjustment factor is 0.9404.
- The FY 2011 (special) exceptions payment adjustment factor is 0.9996.
- The cumulative adjustment factor for FY 2011 applied to the national capital Federal rate for changes in documentation and coding under the MS–DRGs is 0.9574.

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

classifications and relative weights and for changes in the GAFs.

We are providing the following chart that shows how each of the factors and adjustments for FY 2011 affects the computation of the FY 2011 national capital Federal rate in comparison to the FY 2010 national capital Federal rate. The FY 2011 update factor has the effect of increasing the capital Federal rate by 1.5 percent compared to the FY 2010 capital Federal rate. The GAF/DRG budget neutrality factor of 0.9990 has the effect of decreasing the capital Federal rate by 0.10 percent. The FY 2011 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.78 percent compared to the FY 2010 capital Federal rate. The FY 2011 exceptions payment adjustment factor has the effect of decreasing the capital Federal rate by 0.02 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 cumulative adjustment factor of 0.9574 has the net effect of decreasing the FY 2011 national capital Federal rate by 2.80 percent as compared to the FY 2010 national capital Federal rate. (As discussed in section VI.E.1. of the preamble of this final 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 adjustments to the capital Federal rate in FY 2010). The combined effect of all the changes will decrease the national capital Federal rate by approximately 2.2 percent compared to the FY 2010 national capital Federal rate.

Comparison of Factors and Adjustments: FY 2010 Capital Federal Rate and FY 2011 Capital Federal Rate

	FY 2010	FY 2011	Change	Percent Change
Update Factor[1]	1.0120	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor[1]	0.9994	0.9990	0.9990	-0.10
Outlier Adjustment Factor[2]	0.9478	0.9404	0.9922	-0.78
Exceptions Adjustment Factor[2]	0.9998	0.9996	0.9998	-0.02
MS-DRG Documentation and Coding Adjustment Factor	0.9850[3]	0.9574[4]	0.9720[5]	-2.80
Capital Federal Rate[6]	$429. 56	$420.01	0.9778	-2.22

[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 0.9990 GAF/DRG budget neutrality factor for FY 2011 is a net change of 0.9990.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2011 outlier adjustment factor is 0.9404/0.9478, or 0.9922.

[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 -2.9 percent in FY 2011.

[5]The change is measured from the FY 2009 cumulative factor of 0.9850.

[6] Calculated using unrounded factors.

We also are providing the following chart that shows how the final FY 2011 capital Federal rate differs from the proposed FY 2011 capital Federal rate as presented in the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule.

Comparison of Factors and Adjustments: Proposed FY 2011 Capital Federal Rate and Final FY 2011 Capital Federal Rate

	Proposed FY 2011	Final FY 2011	Percent Change
Update Factor	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor	1.0015	0.9990	-0.10
Outlier Adjustment Factor	0.9432	0.9404	-0.30
Exceptions Adjustment Factor	0.9997	0.9996	-0.01
MS-DRG Documentation and Coding Adjustment Factor	0.9570	0.9574	0.00
Capital Federal Rate	$422.18	$420.01	-0.51

6. Special Capital Rate for Puerto Rico Hospitals

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

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

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The national GAF budget neutrality factor is 1.0005 and the DRG adjustment is 0.9991, 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 Pub. L. 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 $203.57 (75 FR 31128). 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 final rule, consistent with our development of the Puerto Rico-specific operating standardized amount, we applied a −2.6 percent adjustment to account for changes in documentation and coding that resulted from the adoption of the MS–DRGs in determining the FY 2011 Puerto Rico-specific capital rate. With the changes we made to the other factors used to determine the capital rate, the FY 2011 special capital rate for hospitals in Puerto Rico is $197.66.

B. Calculation of the 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) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (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 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 $23,075.

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/RY 2010 LTCH PPS final rule (74 FR 44021), 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. (second quarter of 2010), we are forecasting the FY 2006-based CIPI to increase 1.2 percent in FY 2011. This reflects a projected 1.7 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 1.6 percent increase in other capital expense prices in FY 2011, partially offset by 2.1 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. 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.)

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24016 and 24082), we proposed that the FY 2011 rate-of-increase percentage for updating the target amounts for cancer and children's hospitals and RNHCIs was the estimated percentage increase in the FY 2011 IPPS operating market basket, estimated to be 2.4 percent, in accordance with applicable regulations at § 413.40. We also proposed to use the most recent data when determining the estimated percentage increase for the FY 2011 IPPS market basket for the final rule, to the extent these data were available. For this final rule, we are using the most recent data available to determine the FY 2011 IPPS operating market basket. Based on IHS Global Insight, Inc.'s second quarter 2010 forecast, with historical data through the 2010 first quarter, the IPPS operating market basket is 2.6 percent for FY 2011. Therefore, for cancer and children's hospitals and RNHCIs, the FY 2011 rate-of-increase percentage that is applied to the FY 2010 target amounts in order to determine the FY 2011 target amount is 2.6 percent.

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

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VII. of the preamble and section V. of the Addendum to this final rule for the update changes to the Federal payment rates for LTCHs under the LTCH PPS for FY 2011. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Changes to the Payment Rate for the LTCH PPS for FY 2011

A. LTCH PPS Standard Federal Rate for FY 2011

1. Background

In section VII. of the preamble of this final rule, we discuss our changes to the payment rates, factors, and specific policies under the LTCH PPS for FY 2011. As discussed earlier, we note that the Affordable Care Act made a number of changes that affected the LTCH PPS for FY 2010 and FY 2011. Because we were unable to incorporate the provisions of the Affordable Care Act in the FY 2011 IPPS/LTCH PPS proposed rule that appeared in the **Federal Register** on May 4, 2010 due to the timing of enactment of the Affordable Care Act, we issued in the **Federal Register** on June 2, 2010, a supplemental proposed rule that proposed to implement the provisions of the Affordable Care Act affecting the IPPS and LTCH PPS for FY 2011. The final policies and payment rates in this final rule reflect the applicable provisions of this new legislation and address the public comments that we received on both the May 4, 2010 proposed rule and the June 2, 2010 supplemental proposed rule. We also note that we issued a final notice in the **Federal Register** on June 2, 2010, to implement the provisions of the Affordable Care Act that affect the policies and payment rates 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 a 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. Thus, 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 effect of documentation and coding in a prior period that was unrelated to patients' 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 was zero percent based on the most recent estimate of the LTCH PPS market basket at that time, offset by an adjustment to account for changes in case-mix in prior periods due to the effect of documentation and coding that were unrelated to patients' severity of illness in FY 2004. For RYs 2008 through 2010, we also

considered the effect of documentation and coding that was unrelated to patients' 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 FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022), 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 of 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 the effect of documentation and coding unrelated to an increase in patients' severity of illness. 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. However, as noted above, the Affordable Care Act revised the update to the standard Federal rate for RY 2010. Newly added section 1886(m)(3)(A)(ii) of the Act provides that, for each of RYs 2010 through 2019, any annual update to the standard Federal rate is reduced by the "other adjustment" described in section 1886(m)(4) of the Act. Specifically, newly added sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act require a 0.25 percentage point reduction to the annual update to the standard Federal rate for RY 2010. Section 1886(m)(3)(A) of the Act, on its face, explicitly provides for a revised annual update to the standard Federal rate beginning RY 2010, thus resulting in a single revised RY 2010 standard Federal rate. Section 3401(p) of Public Law 111–148 provides that, notwithstanding the previous provisions of this section, the amendments made by subsections (a), (c) and (d) shall not apply to discharges occurring before April 1, 2010. When read in conjunction, we believe section 1886(m)(3)(A) of the Act and section 3401(p) of Public Law 111–148 provide for a single revised RY 2010 standard Federal rate. However, for payment purposes, discharges occurring on or after October 1, 2009, and before April 1, 2010, simply will not be paid based on the revised RY 2010 standard Federal rate (and will be paid based on the standard Federal rate of $39,896.65 as established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022)).

Accordingly, in the June 2, 2010 FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31128), we established an update to the LTCH PPS standard Federal rate for RY 2010 of 1.74 percent, based on the full forecasted estimated increase in the LTCH PPS market basket (2.5 percent), adjusted by the 0.25 percentage point reduction required by sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act, and an adjustment to account for the increase in case-mix in a prior period (FY 2007) resulting from the effect of documentation and coding of −0.5 percent.

As discussed in section VII.C.2.c. of the preamble of this final rule, we are finalizing the proposal contained in the June 2, 2010 FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30969) to revise § 412.523(c)(3)(vi) to specify that the standard Federal rate for the LTCH PPS rate year beginning October 1, 2009 and ending September 30, 2010, is the standard Federal rate for the previous rate year updated by 1.74 percent. Furthermore, consistent with section 3401(p) of Public Law 111–148, in this final rule, we also are finalizing our proposal to revise § 412.523(c)(3)(vi) to specify that with respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate in § 412.523(c)(3)(v) updated by 2.0 percent (75 FR 30969).

2. Development of the 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 effect of documentation and coding practices that does not reflect increased 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 patients' 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 the effect of documentation and coding that does not reflect any real changes in case-mix during these years that we are implementing MS–LTC–DRGs. As described 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 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 documentation and coding on the increase in case-mix in FY 2008, in that same 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, as discussed in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24045 through 24047), we performed a case-mix 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 case-mix of 2.5 percent due to the effect of documentation and coding that did not reflect real changes in severity of illness for LTCH discharges occurring in FY 2008 and FY 2009. Consistent with our historical practice, in that same proposed rule, we proposed to update the LTCH PPS standard Federal rate for FY 2011 based on the full proposed LTCH PPS market basket increase estimate at that time (2.4 percent) and a proposed adjustment to account for the increase in case-mix in prior periods (FYs 2008 and 2009) that resulted from the effect of documentation and coding practices of −2.5 percent. As noted above in this section, although a number of the provisions of the Affordable Care Act affect the LTCH PPS, due to the timing of the passage of that legislation, we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule. Therefore, the proposed policies and payment rates in that proposed rule did not reflect the new legislation. We addressed the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2011 under the LTCH PPS in the June 2, 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30918).

As discussed in the June 2, 2010 FY 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30969), section 1886(m)(3)(A)(ii) of the Act provides that, for each of RYs 2010 through 2019, any annual update to the standard Federal rate is reduced by the "other adjustment" described in section 1886(m)(4) of the Act. Specifically, sections 1886(m)(3)(A)(ii) and (m)(4)(B) of the Act require a 0.50 percentage point reduction to the annual update to the standard Federal rate for FY 2011. Consistent with our historical practice, in that same supplemental proposed rule, we proposed to update the LTCH PPS standard Federal rate for FY 2011 based on the full proposed LTCH PPS market basket increase estimate at that time (2.4 percent), adjusted by the 0.50 percentage point reduction required by sections 1886(m)(3)(A)(ii) and (m)(4)(B) of the Act, and a proposed adjustment to account for the increase in case-mix in prior periods (FYs 2008 and 2009) that resulted from the effect of documentation and coding practices (−2.5 percent). Consequently, we proposed an update factor to the standard Federal rate for FY 2011 of −0.59 percent (that is, we proposed to apply a factor of 0.9941 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.019×1 divided by 1.025 = 0.9941 or −0.59 percent (0.9941 minus 1 equals 0.59 percent)).

Consistent with our historical practice of updating the standard Federal rate for the previous rate year, we applied the proposed update factor of 0.9941 to the revised RY 2010 standard Federal rate that was established in accordance with the provisions of sections 1886(m)(3)(A)(ii) and (m)(4)(A) of the Act (that is, $39,794.95 as established in the FY 2010 IPPS/RY 2010 LTCH PPS final notice (75 FR 31128 through 31129). Consequently, the proposed standard Federal rate for FY 2011 was $39,560.16.

Furthermore, in the June 2, 2010 FY 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30971), we proposed 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 −0.59 percent. We also proposed 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.

In this final rule, as discussed in greater detail in section VII.C.3. of the preamble of this final rule, we are finalizing our proposal to apply a −2.5 percent adjustment to the standard Federal rate to account for the effect of documentation and coding that did not reflect real changes in patient severity of illness for LTCH discharges that occurred in FYs 2008 and 2009 based on our case-mix 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. At this time, as discussed in section VII.C.2. of the preamble of this final rule, the most recent estimate of the increase in the LTCH PPS market basket (that is, the FY 2002-based RPL market basket) for FY 2011 is 2.5 percent. Consistent with our historical practice and as we proposed, in this final rule, we are establishing an update to the LTCH PPS standard Federal rate for FY 2011 based on the full LTCH PPS market basket increase estimate, including the statutorily required 0.50 percentage point reduction, of 2.0 percent and an adjustment to account for the increase in case-mix in prior periods (FYs 2008 and 2009) that resulted from the effect of documentation and coding practices of −2.5 percent. Accordingly, the update factor to the standard Federal rate for FY 2011 is −0.49 percent (that is, we are applying a factor of 0.9951 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.020×1 divided by 1.025 = 0.9951 or −0.49 percent).

Therefore, in this final rule, under the broad authority conferred upon the Secretary under the BBRA and the BIPA to determine appropriate updates under the LTCH PPS and under the authority of sections 1886(m)(3)(A)(ii) and (m)(4)(B) of the Act, consistent with our proposal, we are revising § 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 −0.49 percent. Consistent with our historical practice, and as we proposed, in determining the standard Federal rate for FY 2011, we are applying the update factor of 0.9951 to the RY 2010 Federal rate of $39,794.95 (as established in the June 2, 2010 FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31128 through 31129)). Consequently, in this final rule, we are establishing a standard Federal rate for FY 2011 of $39,599.95, which will apply to LTCH PPS discharges occurring on or after October 1, 2010 through September 30, 2011.

B. 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. 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). In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24084), 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 presented the following update to our titles and definitions using the Executive OMB's bulletin, which is effective for discharges occurring on or after October 1, 2010. We did not receive any public comments on our update to the CBSA titles and definitions for FY 2011.

For FY 2011, as presented in the FY 2011 IPPS/LTCH PPS proposed rule, 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 FY 2011 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this final rule reflect the updates to the CBSA-based labor market area titles and codes described above.

3. LTCH PPS Labor-Related Share

As noted above in this section, under the adjustment for difference in area wage levels at § 412.525(c), the labor-related share of a LTCH's PPS 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).)

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24085), we proposed a labor-related share under the LTCH PPS for FY 2011 of 75.407 percent based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011, as these were the most recent available data at that time. Consistent with our historical practice of using the best data available, we also proposed that if more recent data were 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. We did not receive any public comments on our proposed update to the labor-related share for FY 2011.

As discussed in greater detail in section VII.C.2.d. of the preamble of this final rule, we are using IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the labor-related share for the LTCH PPS for FY 2011 that will be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data. As we proposed, the labor-related share for FY 2011 is the sum of the FY 2011 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and FY 2011. The sum of the relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) is 71.384 percent and the labor-related share of capital costs is 3.887 percent. Thus, under the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are establishing a labor-related share of 75.271 percent (71.384 percent + 3.887 percent) under the LTCH PPS for the FY 2011, as shown in the chart in section VII.C.2.d. of the preamble of this final rule.

4. 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.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24085 through 24086), to determine the applicable wage index values under the LTCH PPS for FY 2011, consistent with our historical methodology, we proposed 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. 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 that 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).) In that same proposed rule, we proposed to compute the FY 2011 LTCH PPS wage index values consistent with the urban and rural geographic classifications (labor market areas) 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 proposed to continue to use our existing policy for determining wage index values in areas where there are no IPPS wage data. We received no comments on our proposed wage index for FY 2011, and are adopting our proposed methodology as final in this final rule, which is described below.

For this final rule, consistent with our historical methodology and as we proposed, 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, we are using 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. We are using FY 2007 data because these data are the most recent complete data available. These are the same data used to compute the FY 2011 acute care hospital inpatient wage index, as discussed in section III. of the preamble of this final rule. (As noted above, 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).)

As we proposed, the FY 2011 LTCH PPS wage index values we are establishing in this final rule are computed consistent with the urban and rural geographic classifications (labor market areas) discussed above in section V.B.2. of the Addendum to this final rule and consistent with the pre-reclassified

IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). As we noted in the proposed rule, 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 final rule). Furthermore, as we proposed, in determining the FY 2011 LTCH PPS wage index values in this final rule, we continued to use our existing policy for determining wage index values in areas where there are no IPPS wage data.

As discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 2408), 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 as we proposed, we continued 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 FY 2007 IPPS wage data that we are using to determine the FY 2011 LTCH PPS wage index values in this final rule, there are no IPPS wage data for the urban area Hinesville-Fort Stewart, GA (CBSA 25980). (We note, based on the data used for the proposed rule, there were no IPPS wage data for the urban area of Anderson, SC (CBSA 11340). However, based on the updated IPPS wage data used for this final rule, there is now data to compute a wage index value for CBSA 11340; therefore, it is no longer necessary to use our established methodology for determining a wage index value for areas that have no IPPS wage data for CBSA 11340 for FY 2011 in this final rule.) Consistent with the methodology discussed above, as proposed, we calculated the FY 2011 wage index value for CBSA 25980 as the average of the wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (reflected in Table 12A of the Addendum to this final rule). (As noted above, there are currently no LTCHs located in CBSA 25980.) As noted in the proposed rule, as IPPS wage data are dynamic, it is possible that urban areas without IPPS wage data will vary in the future.

As we proposed, in this final rule 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 that we are using to determine the FY 2011 LTCH PPS wage index values in this final rule, there are no IPPS wage data for the rural area of Massachusetts (CBSA code 22). Consistent with the methodology discussed above, as proposed, the 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 FY 2011 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the FY 2011 wage indexes for Barnstable County and Bristol County (reflected in Tables 12A and 12B in the Addendum to this final rule). (There are currently no LTCHs located in rural Massachusetts.) As noted above, as IPPS wage data are dynamic, it is possible that rural areas without IPPS wage data will vary in the future.

The FY 2011 LTCH wage index values that will 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 final rule.

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the FY 2010 IPPS/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.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24086), for FY 2011, consistent with our current policy, we proposed to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in the chart in section V.B.5. of the Addendum to the proposed rule because those factors were the most recent available data at that time. The proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and were also proposed to be used under the IPPS, effective October 1, 2010 (section II.B.2. of the Addendum to the proposed rule). We also noted that there had been no change in the COLA factors since the current factors were established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. Furthermore, we proposed that if OPM released 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. We did not receive any public comments on our proposed COLA to payments to LTCHs located in Alaska and Hawaii for FY 2011. We note OPM has not released revised COLA factors since the publication of the proposed rule.

In this final 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, consistent with our current policy, we will apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in the chart below because they are the most recent available data at this time. These factors were obtained from the U.S. Office of Personnel Management (OPM) and will also be used under the IPPS, effective October 1, 2010 (section II.B.2. of the Addendum to this final rule). As noted above, there has been no change in the COLA factors since the current factors were established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule.

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. 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 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 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24087), 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 proposed 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.

In this final rule, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(f)(4)(iii)(B) for SSOs, consistent with our policy of using the best available data and using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the March 2010 update of the PSF, we are establishing a total CCR ceiling of 1.231 under the LTCH PPS that will 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 or MAC 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 or MAC 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24087), 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 proposed 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 that proposed rule.

In this final rule, consistent with our historical practice of using the best available data and using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the March 2010 update of the PSF, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2010, through September 30, 2011, in Table 8C of the Addendum to this final rule.

As we noted in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24088), all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this final rule. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2010. Therefore, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum to this final rule.

In addition, as we discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24088), consistent with our existing methodology, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, in this final 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 the FY 2007 IPPS 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 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 the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24088), we proposed 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 that 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 used the most recent available LTCH claims data and CCR data at that time. Specifically, 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 also proposed that if more recent LTCH claims data become available, we would use them for determining the fixed-loss amount for FY 2011 in the final rule. Furthermore, we proposed to determine the 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.

As noted above in section V.A. of this Addendum, although a number of the provisions of the Affordable Care Act affected the LTCH PPS, due to the timing of the passage of the legislation, we were unable to address those provisions in the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule, and therefore, the proposed policies and payment rates in that proposed rule did not reflect the new legislation. We addressed the provisions of the Affordable Care Act that affected our proposed policies and payment rates for FY 2011 under the LTCH PPS in the June 2, 2010 FY 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30918). In that supplemental proposed rule (75 FR 30980 through 30981), we proposed a revised standard Federal rate for FY 2011 that was developed consistent with the provisions of newly added sections 1886(m)(3)(A)(ii) and (m)(4)(B) of the Act. This revision to the proposed standard Federal rate for FY 2011 also required us to revise the proposed HCO fixed-loss amount for FY 2011. This was necessary in order to maintain the requirement that the fixed-loss amount results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments.

In the June 2, 2010 FY 2010 IPPS/LTCH PPS supplemental proposed rule (75 FR 30981), under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we proposed to establish a fixed-loss amount of $19,254 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 $19,254). We also discussed that the proposed fixed-loss amount of $19,254 for FY 2011 is slightly higher than the revised RY 2010 fixed-loss amount of $18,615 (established in the June 2, 2010 FY 2010 IPPS/RY 2010 LTCH PPS notice (75 FR 31130)). Based on our payment simulations using the most recent available data at that time and the proposed 0.59 percent reduction to the standard Federal rate for FY 2011, the proposed 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, as noted above, 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 believed that proposing to raise the fixed-loss amount was 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).

Comment: One commenter expressed concern that CMS erred in its calculation or changed its methodology for determining the proposed fixed-loss amount of $19,254 for FY 2011, and requested that CMS review its calculation of the FY 2011 fixed-loss amount for the final rule. The commenter stated that its calculation of the fixed-loss amount for FY 2011 was "significantly lower" than the proposed fixed-loss amount of $19,254. The commenter suggested that CMS may have failed to account for cost inflation when using the FY 2009 LTCH claims data or that CMS may have incorrectly computed the "blend" for SSO cases (that is, the SSO payment option at § 412.529(c)(2)(iv)) that are also eligible for HCO payments.

Response: We reviewed our calculation of the proposed FY 2011 fixed-loss amount of $19,254 from the FY 2011 IPPS/LTCH PPS proposed rule, and we have found no errors or misapplication of our stated methodology. Specifically, we have ensured that our calculation accounts for cost inflation when using the FY 2009 claims data to estimate HCO and SSO payments for FY 2011 as we noted in the FY 2011 IPPS/LTCH PPS proposed rule. Consistent with our historical practice, we stated in the FY 2011 IPPS/LTCH PPS proposed rule that to model HCO and SSO payments for FY 2011 we applied an inflation factor of 1.049 (determined by our actuaries) 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 (75 FR 31113). We also reviewed our calculations to ensure that we were correctly determining SSO payments, especially for those SSO cases that are eligible for HCO payments, and found no miscalculations. As noted below, generally it is only in rare circumstances that a LTCH case qualifies as both a SSO case and a HCO case. In fact, SSO cases that are eligible for HCO payments typically represent less than 1 percent of all LTCH cases and, therefore, have little effect on the derivation of the fixed-loss amount. Therefore, we are adopting our proposed methodology as final and consistent with our proposal, we applied that methodology to the latest available data to determine the FY 2011 fixed-loss amount in this final rule.

For FY 2011, in this final rule, as proposed, we continue to use our existing methodology to calculate the fixed-loss amount (based on updated data and the rates and policies presented in this final 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 PPS 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, as we proposed, in determining the fixed-loss amount for FY 2011, we use the most recent available LTCH claims data and CCR data. Specifically, for this final rule, we used LTCH claims data from the March 2010 update of the FY 2009 MedPAR files and CCRs from the March 2010 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. Furthermore, as we proposed, we determined the 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, Version 28.0 of the GROUPER (discussed in section VII.B. of the preamble of this final rule).

In this final rule, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are establishing a fixed-loss amount of $18,785 for FY 2011. Thus, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $18,785).

The fixed-loss amount for FY 2011 of $18,785 is slightly higher than the RY 2010 fixed-loss amount of $18,425. As discussed in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30981) and as reiterated above, we believe that increasing 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). We also note that the FY 2011 fixed-loss amount of $18,785 is slightly less than the proposed FY 2011 fixed-loss amount of $19,254. We believe that the increase in the LTCH PPS FY 2011 market basket estimate from 1.9 percent in the FY 2011 IPPS/LTCH PPS supplemental proposed rule (that is, the estimated full market basket percentage increase of 2.4 percent minus 0.50 percentage point) to 2.0 percent for this final rule (that is, the estimated full market basket percentage increase of 2.5 percent minus 0.50 percentage point) contributed to a slightly lower final HCO fixed-loss amount for FY 2011. Specifically, the additional 0.1 percentage point increase to the standard federal rate increases payments to all cases, which reduces the amount of HCO payments for "unusually costly" cases, and therefore requires that we establish a lower fixed-loss amount for FY 2011 (as compared to the proposed FY 2011 fixed-loss amount) to increase HCO payments in order to maintain the established HCO payment "target" of 8 percent of total estimated LTCH PPS payments.

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 fixed-loss amount of $18,785 and the amount paid under the SSO policy as specified in § 412.529).

D. Computing the Adjusted LTCH PPS Federal Prospective Payments for FY 2011

In accordance with § 412.525, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 12A and 12B of the Addendum of this final rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in the chart in section V.C.5. of the Addendum of this final rule). In this final rule, we are establishing a standard Federal rate for FY 2011 of $39,599.95, as discussed in section VII.C.2. of the Addendum of this final rule. We illustrate the methodology to adjust the 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 FY 2011 LTCH PPS wage index value for CBSA 16974 is 1.0593 (Table 12A of the Addendum of this final rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a relative weight for FY 2011 of 1.0928 (Table 11 of the Addendum of this final rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($39,599.05) by the labor-related share (75.271 percent) and the wage index value (1.0593). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (24.729 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the MS–LTC–DRG relative weight (1.0928) to calculate the total

adjusted Federal LTCH PPS prospective payment for FY 2011 ($45,206.43). The table below illustrates the components of the calculations in this example.

Unadjusted Standard Federal Prospective Payment Rate	$39,599.95
Labor-Related Share	× 0.75271
Labor-Related Portion of the Federal Rate	= $29,807.28
Wage Index (CBSA 16974)	× 1.0593
Wage-Adjusted Labor Share of Federal Rate	= $31,574.85
Nonlabor-Related Portion of the Federal Rate ($39,599.95 × 0.24729)	+ $9,792.67
Adjusted Federal Rate Amount	= $41,367.52
MS–LTC–DRG 28 Relative Weight	× 1.0928
Total Adjusted Federal Prospective Payment	= $45,206.43

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 1E, 2, 3A, 3B, 4A, 4B, 4C, 4D–2, 4E, 4F, 4J, 5, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, 11, 12A, and 12B are presented below. The following tables are available only through the Internet on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/:*

Table 6G.—Additions to the CC Exclusions List
Table 6H.—Deletions From the CC Exclusions List
Table 6I.—Complete MCC List
Table 6I.1.—Additions to the MCC List
Table 6I.2.—Deletions to the MCC List
Table 6J.—Complete CC List
Table 6J.1.—Additions to the CC List
Table 6J.2.—Deletions to the CC List
Table 6K.—Complete List of CC Exclusions

The tables presented below are as follows:

Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (68.8 Percent Labor Share/31.2 Percent Nonlabor Share If Wage Index Is Greater Than 1)
Table 1B.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Capital Standard Federal Payment Rate
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Table 2.—Acute Care Hospitals Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2009; 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
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Table 4A.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Urban Areas by CBSA and by State—FY 2011
Table 4B.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Rural Areas by CBSA and by State—FY 2011
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Table 4D–2.—States Designated as Frontier, with Acute Care Hospitals Receiving at a Minimum the Frontier State Floor Wage Index; 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
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Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2009 MedPAR Update—March 2010 GROUPER V27.0 MS–DRGs
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Table 8A.—Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—July 2010
Table 8B.—Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals— July 2010
Table 8C.—Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs— July 2010
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)—July 2010
Table 11.—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.—LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2010 Through September 30, 2011
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TABLE 1A.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (68.8 PERCENT LABOR SHARE/31.2 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)

Full Update (2.35 Percent)		Reduced Update (0.35 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,552.91	$1,611.20	$3,483.49	$1,579.72

TABLE 1B.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)

Full Update (2.35 Percent)		Reduced Update (0.35 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,201.75	$1,962.36	$3,139.19	$1,924.02

TABLE 1C.— ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,552.91	$1,611.20	$3,201.75	$1,962.36
Puerto Rico	$1,518.14	$926.53	$1,515.70	$928.97

TABLE 1D.— CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$420.01
Puerto Rico	$197.66

TABLE 1E.— LTCH STANDARD FEDERAL PROSPECTIVE PAYMENT RATE

	Rate
Standard Federal Rate	$39,599.95

TABLE 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2009; 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	0.8357	25.0592	24.8712	25.8517	25.2631
010005	1.2841	0.8620	25.7771	24.9052	26.9102	25.8329
010006	1.4782	0.8112	25.1401	26.7013	27.9230	26.5395
010007	1.0377	0.7436	22.0185	20.0565	21.0497	21.0322
010008	1.1123	0.7801	23.2572	22.8443	24.6709	23.5874
010009	0.9990	0.8620	25.8420	26.1396	28.0151	26.6260
010010	1.2246	0.7762	24.8390	26.2416	27.1942	26.0929
010011	1.5830	0.8587	27.1997	28.6140	33.0321	29.6010
010012	1.1634	0.7613	26.4989	24.8944	25.4118	25.5679
010015	0.9011	0.7491	23.6821	22.9857	22.2054	22.9341
010016	1.5802	0.8587	28.9724	28.7392	30.3929	29.3859
010018	1.1555	0.8587	26.9514	26.7633	28.8046	27.5172
010019	1.3603	0.8112	25.0170	26.0567	29.0591	26.7027
010021	1.3329	0.7488	21.7601	24.3385	25.0313	23.6902
010022	0.9217	0.9522	28.7529	26.5348	30.6558	28.6530
010023	1.7864	0.8579	28.2135	30.0684	32.0045	30.1354
010024	1.6738	0.8579	26.6636	28.1766	29.2933	28.0997
010025	1.4344	0.8567	23.8617	20.1873	29.5769	23.9644
010027	0.7496	0.7462	18.2508	19.7740	22.3018	20.2054
010029	1.6510	0.8567	24.3622	28.3184	26.0907	26.1631
010032	0.8693	0.7745	20.8458	24.7706	22.5584	22.8602
010033	2.2117	0.8587	29.2036	29.3762	30.8210	29.8374
010034	1.1730	0.8579	21.3728	21.0565	23.7483	22.0203
010035	1.3475	0.8409	26.5299	28.0534	28.4964	27.6822
010036	1.1875	0.7436	23.3876	25.0011	26.1744	24.8567
010038	1.3776	0.7864	28.9646	29.7948	32.5186	30.4734
010039	1.8330	0.9033	29.8034	30.6619	32.0412	30.8691
010040	1.6522	0.7497	25.9856	25.2840	28.2876	26.5077
010043	1.2776	0.8587	25.3633	27.3636	26.3495	26.3184
010044	1.0295	0.7436	23.4020	27.3403	28.2112	26.2647

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)
010045	1.0535	0.7811	24.2450	25.1108	27.0821	25.4640
010046	1.5582	0.8409	25.4465	33.3112	21.9391	26.0979
010047	0.8765	0.7702	21.7349	17.0984	24.5217	21.0321
010049	1.0744	0.7462	23.1194	25.4446	27.0600	25.1492
010050	1.0266	0.8587	25.3678	27.0365	29.5458	27.2866
010051	0.8615	0.9061	20.0765	21.4140	20.9125	20.8059
010052	0.9419	0.8579	22.7571	22.1386	21.8118	22.2474
010054	1.0674	0.8620	25.4209	24.6126	24.7029	24.9013
010055	1.5928	0.8108	25.3306	26.4706	27.5801	26.4529
010056	1.6143	0.8587	25.7290	28.5668	31.1812	28.4482
010058	0.9816	0.8587	31.1865	23.6860	24.6077	25.8242
010059	1.0664	0.8620	27.8613	29.5434	26.7404	27.9863
010061	0.9602	0.8635	25.7048	26.5035	26.7673	26.3375
010062	1.0748	0.7515	22.9491	20.8224	24.4490	22.6502
010064	1.6120	0.8587	26.6333	*	23.3927	24.8278
010065	1.4982	0.8409	24.4454	25.9433	27.9891	26.1119
010066	0.8151	0.7436	25.6052	25.9301	26.7326	26.0543
010069	0.9679	0.7436	27.3438	29.4662	25.8936	27.5676
010073	0.9744	0.7436	20.7833	19.9743	21.0039	20.5777
010078	1.7376	0.7864	25.2897	24.5429	26.5624	25.4724
010079	1.3594	0.9033	23.1025	25.4118	27.2438	25.2389
010083	1.1948	0.7981	25.0422	25.2405	25.1991	25.1646
010084	***	*	27.5069	*	*	27.5069
010085	1.4769	0.8620	24.0475	25.6072	26.5881	25.3873
010086	1.1077	0.7436	26.9753	24.9468	27.4119	26.3780
010087	2.4471	0.7889	27.4929	27.2725	28.3614	27.7329
010089	1.3862	0.8587	25.9719	26.9357	27.9046	26.8948
010090	1.8308	0.7889	25.6110	26.8029	28.3718	26.9462
010091	0.8685	0.7491	23.6555	27.8571	25.1167	25.3688
010092	1.5529	0.9061	28.8433	30.3263	31.9499	30.4201
010095	0.7991	0.9061	17.8248	21.6551	23.5537	21.0343
010097	0.8060	0.8579	18.4218	19.5147	21.7857	19.8743
010099	0.9382	0.7436	22.3686	20.8632	23.5806	22.2673
010100	1.7378	0.7981	25.4357	25.8178	26.8156	26.0437
010101	1.1605	0.8409	26.2744	25.0955	26.5723	25.9863
010102	0.9608	0.8579	26.6943	22.6883	22.4370	23.9585
010103	1.9636	0.8587	30.4032	27.9049	29.7454	29.3407
010104	1.6984	0.8587	30.4963	29.1001	30.1172	29.9205
010108	1.0545	0.8579	26.8900	27.7601	29.9581	28.3613
010109	1.0134	0.7841	21.9300	19.3990	23.0895	21.4711
010110	0.8328	0.7886	22.1175	17.9438	25.5664	21.8233
010112	0.9041	0.7436	21.3904	22.0927	20.9576	21.4571
010113	1.6548	0.7889	25.0704	25.7852	28.0501	26.3163
010114	1.5070	0.8587	25.3666	25.8015	26.0278	25.7349
010118	1.3294	0.8409	25.3689	25.7663	27.7329	26.2750
010120	0.9119	0.7436	22.8177	22.0809	*	22.4473
010125	1.1026	0.7861	23.6549	24.1942	25.8919	24.5473
010126	1.0242	0.8579	25.7254	28.8995	27.0740	27.1816
010128	0.9834	0.7491	25.9421	25.1022	25.7420	25.6010
010129	1.1598	0.7589	24.4816	25.2104	27.6737	25.7934
010130	1.0145	0.8587	25.2790	23.8895	31.2293	26.5253
010131	1.4270	0.9033	28.0487	28.6759	32.2417	29.7129
010137	1.5361	0.8587	30.4361	30.7312	33.4925	31.5294
010138	0.6398	0.7525	15.0815	16.7541	16.6123	16.1894
010139	1.6830	0.8587	29.3560	29.3626	30.7451	29.8129
010143	1.1691	0.8620	25.0871	25.1522	25.7699	25.3196
010144	1.7207	0.7889	23.8601	25.4614	26.3984	25.1941
010145	1.5795	0.9061	27.3296	30.2093	32.6850	30.1787
010146	0.9412	0.7864	23.8076	24.6572	25.2451	24.5503
010148	0.9563	0.7436	25.0960	24.8409	24.3671	24.7684
010149	1.3663	0.8579	26.8920	28.1328	29.8608	28.3977
010150	1.0187	0.7702	25.0070	26.3342	25.9380	25.7366
010152	1.3718	0.7889	26.0793	23.0248	25.2739	24.7325
010157	1.1568	0.8112	27.1793	27.5674	27.7297	27.4850
010158	1.3394	0.8112	26.2363	26.8821	28.2112	27.1194
010164	1.1777	0.8409	25.6759	24.4625	23.9584	24.6954
010167	1.5767	0.8587	*	24.7643	29.1594	26.8635
010168	1.6115	0.9073	*	30.2040	27.0152	28.8586
010169	1.0410	*	*	*	*	*
020001	1.8974	1.2573	38.1784	39.2651	40.8289	39.4351
020006	1.3723	1.2573	37.2853	40.5422	42.4802	40.2744
020008	1.2207	1.2573	40.6783	42.8075	44.8252	42.8352

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)
020012	1.4672	1.2573	36.1911	37.0181	38.4855	37.2454
020014	***	*	30.6343	*	*	30.6343
020017	2.2168	1.2573	38.2157	41.2448	42.1715	40.5557
020018	0.9117	1.9343	*	*	*	*
020024	1.1323	1.2573	39.9943	35.9358	43.5263	39.9056
020026	1.5829	1.9343	*	*	*	*
020027	0.8544	1.9343	*	*	*	*
020028	***	*	*	*	42.1529	42.1529
030001	1.5123	1.0463	35.9083	38.1204	36.9423	37.0082
030002	2.1395	1.0463	32.9094	34.2998	35.5371	34.2805
030006	1.7866	0.9643	29.1248	32.1646	32.4529	31.2984
030007	1.5010	1.2257	35.5226	38.1199	40.1687	38.0198
030010	1.6899	0.9643	31.8640	33.3049	33.9479	33.0646
030011	1.6799	0.9643	30.2096	31.8532	32.9140	31.7304
030012	1.6785	1.2257	31.3068	33.4818	50.8472	36.5879
030013	1.5846	0.9408	31.9162	31.1767	33.0068	32.0520
030014	1.6003	1.0463	30.6308	31.8529	33.7067	32.1283
030016	1.3364	1.0463	31.1878	30.6196	34.0695	31.9037
030017	***	*	34.8488	34.9499	37.4848	35.7418
030018	***	*	31.7240	34.2870	35.7189	33.8724
030019	***	*	33.6553	36.3298	36.3721	35.4431
030022	1.6387	1.0463	35.0772	34.3377	34.4013	34.5340
030023	2.0211	1.2394	37.5523	41.8098	43.4849	40.9819
030024	2.1783	1.0463	35.3556	38.5575	40.6036	38.3091
030030	1.6996	1.0463	36.4772	38.9056	37.5931	37.7180
030033	1.3578	1.2088	32.0362	33.9716	35.7804	33.9581
030036	1.6971	1.0463	35.7464	37.1271	40.4800	37.7753
030037	1.9779	1.0463	35.1342	35.8129	37.1893	36.2134
030038	1.6840	1.0463	31.2928	33.8052	36.9224	34.1134
030043	1.3149	0.9088	28.3158	29.0816	31.0563	29.4830
030055	1.5838	1.0236	31.0806	37.2632	37.4275	35.3160
030061	1.7125	1.0463	33.0847	34.2000	35.3817	34.2644
030062	1.4495	0.9088	29.9359	30.3859	33.1838	31.2097
030064	2.1061	0.9643	31.6632	33.1535	35.0192	33.3226
030065	1.8343	1.0463	31.4602	33.8941	36.2497	33.8307
030067	1.0416	0.9376	27.0784	27.4410	31.2437	28.5851
030068	1.1142	0.9088	26.0296	26.8369	29.1022	27.3791
030069	1.5878	1.1410	30.7723	35.1793	35.6387	33.9916
030071	1.0518	1.4448	*	*	*	*
030073	1.2775	1.4448	*	*	*	*
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	1.0463	35.8521	39.0888	39.9654	38.3236
030084	1.0830	1.4448	*	*	*	*
030085	1.6913	0.9643	29.0774	30.7160	33.4027	31.0304
030087	1.7697	1.0463	31.1094	33.0362	37.0555	33.8805
030088	1.4335	1.0463	30.5738	33.5408	34.6845	33.0343
030089	1.7404	1.0463	31.3179	32.8874	34.7310	33.0006
030092	1.6022	1.0463	30.4394	31.6471	33.8277	32.0844
030093	1.4573	1.0463	33.0720	33.5029	34.2978	33.6732
030094	1.6808	1.0463	34.2040	35.9213	36.9085	35.7431
030099	0.7231	*	24.9127	*	*	24.9127
030100	2.2953	0.9643	35.0981	36.9783	39.5341	37.2912
030101	1.4411	1.1751	33.2139	34.1060	33.6218	33.6521
030102	2.8130	1.0463	36.9539	39.4617	36.4106	37.5405
030103	1.8002	1.0463	34.2770	41.6469	41.1171	39.1544
030105	2.2878	1.0463	33.9875	37.6952	38.6699	36.8252
030106	***	*	40.1657	43.9022	*	41.9807
030107	2.1093	1.0463	35.4562	35.9171	37.6242	36.3362
030108	2.4034	1.0463	34.8507	33.2799	34.5081	34.1518
030110	1.7329	1.0463	36.2158	38.0468	39.0289	37.8783
030111	1.1668	0.9643	28.5146	33.3314	37.0046	33.6455
030112	2.0671	1.0463	33.4810	36.1513	40.1237	36.8687
030113	0.9505	1.4448	*	*	*	*
030114	1.4510	0.9643	28.8466	30.2128	30.3727	29.8441
030115	1.5083	1.0463	32.5885	34.8409	36.8185	35.0070
030117	1.3318	1.0236	*	34.5349	36.6686	35.7284
030118	1.3327	1.2257	*	28.2945	32.6081	30.4097
030119	1.6200	1.0463	*	38.2362	40.7127	39.6358
030120	0.8520	1.0463	*	39.7676	47.4922	43.8665

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030121	1.6902	1.0463	*	*	36.6960	36.6960
030122	1.4640	1.0463	*	*	35.1748	35.1748
030123	1.4739	1.0463	*	*	*	*
030124	1.8948	1.0463	*	*	*	*
030125	2.0742	1.0463	*	*	*	*
030126	1.8635	1.0463	*	*	*	*
040001	1.0932	0.8604	24.4962	25.0147	25.5812	25.0453
040002	1.1071	0.7479	24.0487	26.2100	24.0612	24.7412
040004	1.7351	0.8604	29.2714	30.1320	31.6093	30.3568
040007	1.7451	0.8650	28.3305	29.3146	30.2019	29.2707
040010	1.4698	0.8604	28.2375	28.1618	29.1994	28.5981
040011	0.9266	0.7479	22.6327	25.6224	25.9607	24.7346
040014	1.3689	0.8461	34.8279	24.1271	24.6909	25.5985
040015	1.0662	0.7479	22.3148	23.2134	23.7368	23.0839
040016	1.7601	0.8650	26.4806	27.6568	28.6478	27.6403
040017	1.0990	0.8458	24.3772	25.3390	26.2486	25.3108
040018	1.2191	0.7713	26.2521	25.3362	26.6818	26.0808
040019	0.9918	0.7732	26.4932	25.5468	25.0465	25.6609
040020	1.6272	0.8920	26.1529	25.9754	26.6025	26.2454
040021	***	*	27.6799	28.7690	28.8877	28.4555
040022	1.4167	0.8604	30.0250	29.5992	29.4497	29.6866
040026	1.6410	0.9249	31.8588	32.2814	34.6908	32.9467
040027	1.5093	0.8485	25.7935	27.2441	28.4708	27.1867
040029	1.4958	0.8650	27.8882	27.8412	29.1955	28.3042
040036	1.6856	0.8650	30.4906	32.0772	33.1192	31.9023
040039	1.1753	0.8119	22.9807	23.4456	23.0732	23.1645
040041	1.1592	0.8461	26.4435	27.8594	27.4407	27.2460
040042	1.3566	0.9244	23.1661	23.5768	28.3839	25.0282
040047	0.9113	0.7516	23.3557	25.0102	27.5107	25.1256
040050	1.1590	0.7479	19.6946	21.0178	22.0118	20.9054
040051	0.9936	0.7479	22.1981	23.4783	24.9273	23.5404
040055	1.7558	0.7713	26.0150	26.3370	26.5669	26.3151
040062	1.6827	0.7713	25.6554	28.5888	28.5361	27.5752
040067	1.0555	0.7525	20.9700	21.3492	22.1743	21.5135
040069	0.9730	0.8119	23.3117	23.0880	22.6962	23.0298
040071	1.5474	0.8461	26.6645	25.0185	28.7092	26.7525
040072	1.1859	0.7479	22.9671	23.3205	24.0462	23.4420
040074	1.1781	0.8650	27.3897	27.4614	27.7882	27.5506
040076	1.0157	0.9026	24.7903	25.7464	25.0248	25.1713
040078	1.7507	0.9249	25.6886	27.9394	28.4445	27.3083
040080	1.0416	0.7794	26.5905	26.9354	26.1189	26.5513
040081	0.8641	0.7877	18.4759	18.5265	17.3942	18.1436
040084	1.3107	0.8650	28.1570	28.7379	29.9606	29.0174
040085	0.9358	0.8920	26.6987	25.4981	26.7517	26.3191
040088	1.5419	0.8163	24.7119	26.7050	28.8839	26.7750
040091	1.1940	0.7479	22.3311	27.7747	29.8964	26.3921
040100	***	*	24.5458	24.7712	*	24.6638
040114	1.9109	0.8650	28.5702	29.1200	30.8836	29.5169
040118	1.6136	0.7479	26.5783	27.3360	30.6023	28.2478
040119	1.5157	0.8461	25.6779	26.9632	28.2717	27.0134
040132	0.8021	0.9249	21.8140	*	22.6928	22.2498
040134	2.2362	0.8650	34.9673	35.2045	36.1586	35.4814
040137	1.3325	0.8650	27.7638	28.2123	31.3210	29.2676
040138	***	*	33.0073	31.1138	32.5968	32.2147
040141	***	*	33.8791	34.8500	*	34.4114
040142	1.5826	0.9249	23.1302	24.4876	27.5048	25.1138
040145	1.9580	0.7794	20.3878	22.1731	22.3652	21.7113
040147	1.9130	0.8650	35.7669	33.6215	30.4208	32.7918
040148	***	*	*	*	35.5993	35.5993
040149	***	*	*	*	29.0681	29.0681
040152	2.5966	0.8604	*	*	*	*
050002	1.5159	1.6174	43.1760	42.3825	45.4903	43.6732
050006	1.8102	1.3551	41.7714	43.8923	45.0049	43.5841
050007	1.5598	1.5582	49.5271	55.1636	52.2197	52.2495
050008	1.6354	1.5352	50.9569	50.4751	52.7621	51.4034
050009	1.7626	1.5477	49.7177	51.5510	53.0532	51.5272
050013	1.9184	1.5477	43.4906	46.3422	49.5412	46.5158
050014	1.2657	1.3602	42.2044	42.7255	41.0167	41.9531
050016	1.4193	1.2371	34.3863	36.3674	39.4544	36.8695
050017	2.1061	1.3602	44.4857	46.6209	50.4721	47.2153
050018	1.3007	1.2014	34.0338	34.7941	36.0292	34.9605
050022	1.7904	1.1870	36.6360	38.9203	41.5417	39.0959

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050024	1.2891	1.1870	33.5247	34.6921	37.1766	34.9045
050025	1.9538	1.1870	36.9233	39.5330	43.2514	40.0031
050026	1.6191	1.1870	35.0306	36.3315	37.3252	36.2921
050028	1.2261	1.1870	28.1584	28.5839	27.8645	28.1884
050030	1.2680	1.1870	33.5654	33.2455	34.4663	33.7619
050036	1.7457	1.1870	37.4298	39.2616	41.5347	39.4691
050038	1.7728	1.6379	55.2197	58.4851	61.3195	58.4318
050039	1.5400	1.1870	34.9262	37.8559	40.5046	37.7051
050040	1.3721	1.2014	38.1665	41.9767	44.2838	41.5359
050042	1.5785	1.3551	40.5791	45.6660	51.0704	45.8231
050043	1.7576	1.6174	51.9529	55.4677	53.5357	53.6943
050045	1.3696	1.1870	28.5952	27.8903	31.4824	29.3275
050046	1.2182	1.2318	34.2529	34.0106	37.1954	35.1667
050047	1.8545	1.5352	48.5961	51.4298	54.2387	51.4093
050054	1.2411	1.1870	27.1320	27.9082	32.4908	29.1681
050055	1.4904	1.5352	48.2796	51.9993	52.9292	51.0864
050056	1.5972	1.2014	34.7964	33.2655	39.4908	35.7782
050057	1.6940	1.1870	33.7574	35.6340	38.6094	36.0654
050058	1.8187	1.2014	38.9843	41.4811	43.4722	41.3495
050060	1.6287	1.1870	34.1183	35.3108	36.7704	35.4298
050063	1.6524	1.2014	36.6301	40.9558	43.3548	40.2736
050065	***	*	42.0085	*	*	42.0085
050067	1.3773	1.2145	41.8988	41.1549	34.0172	39.0731
050069	2.0169	1.2014	38.1339	40.0498	44.2594	40.8820
050070	1.4481	1.5582	48.9362	53.8300	55.6216	52.8271
050071	1.7718	1.6379	52.0696	55.3995	54.9090	54.1684
050072	1.5282	1.5852	51.4538	54.7774	55.8232	54.0506
050073	1.5376	1.5739	50.6523	54.2296	55.8294	53.6350
050075	1.6153	1.6174	51.1187	54.8332	56.6302	54.2161
050076	1.8135	1.5352	50.5761	53.8043	55.1767	53.1991
050077	1.6624	1.1870	37.4989	38.5242	41.3278	39.1676
050078	1.3299	1.2014	37.1940	38.9256	38.8451	38.3334
050079	1.5469	1.5852	48.3017	50.6578	65.1362	53.7654
050082	1.8234	1.2318	42.0181	41.8861	44.1020	42.6925
050084	1.6992	1.3602	41.1276	42.4418	46.0204	43.2676
050089	1.4757	1.2014	39.6297	39.9711	42.3945	40.7105
050090	1.4461	1.5765	41.6026	44.0838	44.4578	43.3834
050091	0.9802	1.2014	40.1063	34.8170	33.6693	36.0049
050093	1.5991	1.1870	37.7244	38.5686	41.6165	39.3778
050095	***	*	44.2400	*	*	44.2400
050096	1.4571	1.2014	33.3803	27.6236	33.2802	31.4262
050099	1.6444	1.2014	34.3507	35.4717	37.9257	35.9472
050100	1.8716	1.1870	34.2839	37.1606	39.4278	36.9809
050101	1.6391	1.5739	48.7495	54.5185	56.6054	53.4136
050102	1.4707	1.1870	33.2837	35.4740	35.1216	34.5854
050103	1.6949	1.2014	37.3608	38.8446	38.1681	38.1414
050104	1.5783	1.2014	37.4417	39.1121	41.8902	39.5418
050107	1.6748	1.1870	36.5843	40.5315	41.5153	39.5943
050108	2.0166	1.3602	45.3460	48.8199	53.1599	48.7790
050110	1.2043	1.1870	30.9054	32.3171	33.5895	32.2742
050111	1.0887	1.2014	31.9394	31.1160	32.2546	31.7680
050112	1.5483	1.2014	39.9951	41.8195	41.5860	41.1888
050113	1.4076	1.5582	46.3471	45.1998	42.4731	44.6094
050114	***	*	37.5924	36.6541	*	37.1115
050115	1.5983	1.1870	33.3013	37.7614	40.4348	37.1480
050116	1.7304	1.2014	45.7510	40.6863	42.7908	43.0761
050118	1.2522	1.2584	41.8191	43.4432	46.9032	44.0955
050121	1.2757	1.1870	35.1135	36.9069	41.7993	38.1788
050122	1.7509	1.2584	36.8821	40.4510	41.5062	39.6331
050124	1.3527	1.2014	31.7690	33.3080	34.6262	33.2596
050125	1.6861	1.6379	53.6300	57.6242	60.2399	57.1257
050126	1.6064	1.2014	35.1909	34.9807	36.0250	35.4276
050127	1.5461	1.3602	42.5226	46.9648	48.0525	46.1768
050128	1.6196	1.1870	34.2364	36.6986	39.4082	36.7731
050129	1.9659	1.2014	40.3786	41.4256	44.6183	42.2095
050131	1.4681	1.5739	52.8228	56.6586	53.6174	54.3324
050132	1.6276	1.2014	43.6747	42.8187	45.2162	43.9263
050133	1.4848	1.2101	35.2433	36.8254	37.6462	36.6540
050135	1.0726	1.2014	25.4431	28.5118	30.6520	28.0969
050136	1.4481	1.5765	51.8508	52.5398	57.3846	53.8756
050137	1.3773	1.2014	43.5305	45.2088	49.1368	45.8651
050138	1.9128	1.2014	45.1011	47.3839	51.2909	47.9159

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050230	1.7061	1.2014	38.8901	39.8582	42.1510	40.3302
050231	1.8460	1.2014	37.0245	38.7280	40.2311	38.7177
050232	1.7131	1.2371	35.4055	39.4290	42.6868	39.2946
050234	1.5381	1.1870	37.7125	37.6811	38.9567	38.1590
050235	1.7383	1.2014	39.1744	40.0962	40.2224	39.8333
050236	1.5208	1.2318	34.4257	42.5939	44.3745	40.4040
050238	1.7269	1.2014	35.1268	36.4272	37.6163	36.4438
050239	1.6695	1.2014	36.3257	37.2939	38.5898	37.4476
050242	1.4892	1.6379	53.8385	58.5684	59.7274	57.3839
050243	1.6103	1.1870	37.8538	40.0490	42.5251	40.1490
050245	1.3766	1.2014	34.7153	36.9270	38.8242	36.8798
050248	1.1998	1.5821	46.0329	47.7637	51.0456	48.2727
050254	1.3843	1.3602	33.5069	34.8262	39.7929	36.0813
050256	***	*	32.6841	*	*	32.6841
050257	0.8947	1.1870	29.2651	30.7766	29.8441	29.9442
050261	1.3026	1.1870	33.7196	34.8188	39.2998	36.0503
050262	2.3736	1.2014	43.7709	40.8071	44.0395	42.8167
050264	1.4655	1.6174	50.1691	54.4052	57.0108	53.7373
050272	1.5454	1.2014	32.2584	35.0624	37.3153	34.8941
050276	1.1140	1.5852	47.2432	53.7552	55.4650	52.2495
050277	1.2258	1.2014	*	48.9698	47.5589	48.2281
050278	1.7099	1.2014	38.5689	39.5929	42.8751	40.4104
050279	1.3099	1.2014	32.1695	31.0888	32.0244	31.7613
050280	1.8248	1.3551	43.6243	46.2628	50.0851	46.7045
050281	1.5342	1.2014	31.0706	31.4166	32.8584	31.7844
050283	1.7021	1.6174	45.1132	50.3066	51.3706	48.9667
050289	1.6807	1.5582	52.0918	53.8571	58.3699	54.8719
050290	1.7520	1.2014	42.0099	42.2249	42.6269	42.2971
050291	2.0918	1.5765	44.6102	49.6427	52.1697	48.7269
050292	1.1648	1.1870	35.0372	34.6404	39.9785	36.7536
050295	1.5834	1.1870	39.7399	39.3961	44.1498	41.1199
050296	1.1416	1.6363	44.8135	48.2583	50.4017	47.9040
050298	1.2079	1.1881	33.6947	31.7374	34.0114	33.1333
050300	1.4557	1.2014	37.1275	39.2722	43.0416	39.9992
050301	1.3483	1.1870	36.3681	36.7568	39.9452	37.7758
050305	1.5667	1.6174	56.9756	55.7229	54.8855	55.8154

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)
050139	1.4368	1.2014	43.0734	44.5753	48.6897	45.4234
050140	1.4087	1.2014	42.7590	44.8911	46.8593	44.8766
050144	***	*	40.4760	*	*	40.4760
050145	1.6332	1.5821	49.4479	54.8909	58.5157	54.4123
050146	1.8322	*	*	*	*	*
050149	1.5052	1.2014	43.1926	42.8003	45.3969	43.8105
050150	1.3011	1.3602	43.5937	44.3354	48.0176	45.3163
050152	1.6955	1.5739	54.7176	55.9738	57.1829	55.9878
050153	1.5690	1.6379	50.4884	53.5925	57.8764	54.0626
050158	1.5055	1.2014	42.7874	42.9454	44.0696	43.2813
050159	1.3444	1.2318	35.0153	40.4701	42.5867	39.5644
050167	1.4923	1.2584	38.0742	39.9946	43.2961	40.4580
050168	1.6873	1.2014	40.8362	37.9746	43.4912	40.7637
050169	1.6805	1.2014	33.1130	35.4836	41.1207	36.5875
050173	1.3930	1.2014	32.3265	31.5434	32.8376	32.2537
050174	1.7399	1.5765	53.7113	54.7960	59.7466	56.0817
050179	1.2738	1.2145	34.6558	36.2060	33.9146	34.8595
050180	1.7149	1.5852	48.7425	51.1836	53.5523	51.2518
050188	1.4966	1.6379	45.8501	49.6669	54.1800	49.5964
050189	0.9575	1.5821	31.5805	27.5311	29.3425	29.4649
050191	1.6765	1.2014	41.7185	40.0694	41.5125	41.0732
050192	0.9069	1.1870	27.4611	29.4203	33.2039	30.1249
050193	1.2942	1.2014	36.7240	39.0111	43.0233	39.5117
050194	1.3701	1.6379	49.8539	49.9857	55.1097	51.6929
050195	1.6650	1.6174	57.6563	61.8312	64.9964	61.5420
050196	1.2008	1.1870	41.1300	43.7415	41.0205	41.9819
050197	1.9331	1.6174	55.3173	59.0280	62.6601	59.1169
050204	1.5451	1.2014	38.8689	37.5591	41.0519	39.2198
050205	1.5945	1.2014	30.6117	30.2818	31.5201	30.7764
050211	1.3252	1.6174	42.9254	44.8773	46.1719	44.5805
050219	1.3542	1.2014	26.7061	26.9022	26.0494	26.5438
050222	1.7729	1.1870	35.4045	36.0221	37.6933	36.4268
050224	1.7191	1.2014	37.3442	39.7119	41.8752	39.6756
050225	1.5650	1.1870	37.5252	38.9288	43.5536	40.1155
050226	1.5718	1.2014	36.5354	38.4952	39.4145	38.1212
050228	1.4239	1.5352	49.9063	54.5580	57.3337	54.0668

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)
050308	1.5864	1.6379	49.0132	51.0183	54.0403	51.4711
050309	1.5729	1.3602	42.9280	46.6901	47.4681	45.7094
050313	1.2453	1.2584	39.0663	42.3998	43.8869	41.8584
050315	1.4388	1.1870	37.3560	40.3132	47.1223	41.7222
050320	1.2324	1.6174	50.6708	50.9692	55.3599	52.3363
050324	1.8098	1.1870	37.1883	38.9511	41.4763	39.2613
050325	0.7767	1.1917	34.0343	*	47.6612	36.0495
050327	1.8597	1.2014	36.9550	37.7681	39.6775	38.2010
050329	1.3249	1.1870	36.7669	37.6975	37.0292	37.1617
050334	1.7820	1.6174	50.9834	54.9338	59.6665	55.2787
050335	1.4895	1.2145	37.2347	37.1670	39.9849	38.1999
050336	1.2295	1.2584	33.0325	35.3658	38.7215	35.7896
050342	1.2591	1.1870	29.8389	31.6852	33.8409	31.8482
050348	1.7579	1.2014	33.5276	35.1080	37.4622	35.3759
050349	0.7643	1.1870	23.1095	23.5190	24.5928	23.7423
050350	1.5328	1.2014	34.6747	36.1856	37.1942	35.9735
050351	1.5646	1.2014	35.0042	35.6083	34.8425	35.1376
050352	1.4182	1.3602	38.6265	41.5370	41.4259	40.5205
050353	1.5266	1.2014	37.1716	37.4560	38.3089	37.6434
050357	1.4556	1.1870	38.9244	40.9999	41.7958	40.6062
050359	1.1943	1.1870	30.3988	30.9732	33.5060	31.6291
050360	1.6360	1.5739	55.3738	59.2147	57.2822	57.3296
050366	1.1199	1.3602	41.8324	43.0169	43.1598	42.6722
050367	1.6146	1.5739	40.0453	41.1059	44.3452	41.9301
050369	***	*	33.3357	34.7337	37.3625	35.1715
050373	1.4497	1.2014	37.6695	40.8506	43.5485	40.7397
050376	1.6492	1.2014	36.7270	40.0354	42.6955	39.9313
050378	1.1137	1.2014	42.0480	50.0875	51.4997	47.5440
050380	1.8224	1.6379	52.5804	58.6395	60.9550	57.5346
050382	1.6019	1.2014	32.9248	34.3636	36.6586	34.7189
050385	1.4871	1.5765	36.5644	38.9773	44.2983	40.0212
050390	1.2847	1.1870	33.0463	31.4134	33.7881	32.7361
050393	1.4304	1.2014	35.1887	35.5678	38.9828	36.6221
050394	1.7929	1.2318	32.9572	37.2557	40.0130	36.7463
050396	1.5923	1.1870	38.9944	41.2602	41.6889	40.7016
050397	0.8415	1.1870	31.1621	32.3700	36.0820	33.4767

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)
050407	1.2178	1.5352	47.5591	47.7943	48.9067	48.1129
050411	1.4376	1.2014	42.9884	44.3404	47.5343	44.9695
050414	1.3420	1.3602	45.1621	48.5863	51.4234	48.5009
050417	1.3322	1.1870	37.9951	38.8418	38.4045	38.4255
050423	1.0535	1.1870	32.4108	41.3130	43.7744	38.6486
050424	1.9481	1.1870	37.5246	39.8802	42.7692	40.2142
050425	1.4308	1.3602	45.3743	52.0378	53.7817	50.3012
050426	1.7182	1.2014	37.6505	*	37.1400	37.3870
050430	1.0514	*	25.9368	28.7102	*	27.6338
050433	***	*	23.0949	*	*	23.0949
050434	0.9730	1.1870	35.4807	34.4698	36.3610	35.4595
050435	1.2470	1.1870	35.7427	35.3040	36.3677	35.8139
050438	1.6093	1.2014	38.2855	36.8507	40.3663	38.5324
050441	2.0773	1.6379	49.2129	50.0652	56.1597	51.9891
050444	1.4821	1.2398	39.3947	39.4231	42.2845	40.4135
050447	***	*	27.1271	*	*	27.1271
050448	1.2055	1.1870	32.6682	32.9244	35.5700	33.7502
050454	2.1384	1.5352	43.5230	46.9602	50.2844	47.0752
050455	1.5674	1.1870	35.0232	38.9871	39.4824	37.8758
050456	***	*	27.9702	28.1444	*	28.0651
050457	1.7524	1.5352	53.3175	54.6802	57.2450	55.1006
050464	1.8533	1.2145	42.6699	44.9128	46.6237	44.6823
050468	1.5593	1.2014	37.3416	35.7136	37.0543	36.6926
050470	***	*	32.5041	*	*	32.5041
050471	1.6569	1.2014	36.8185	37.6641	40.5352	38.3225
050476	***	*	41.7566	*	*	41.7566
050478	0.9581	*	41.5635	44.3775	*	43.0127
050481	1.6201	1.2014	42.8536	47.2326	50.1913	46.8121
050485	1.7165	1.2014	34.7078	37.4203	39.3227	37.2214
050488	1.5157	1.6174	49.3604	53.8013	53.3302	52.2005
050492	1.4172	1.1870	32.6609	35.6838	39.5001	36.0804
050496	1.8243	1.5852	56.7446	57.1030	61.4753	58.5040
050498	1.4628	1.3602	45.3508	46.6560	47.7304	46.5600
050502	1.7474	1.2014	32.9791	40.2876	39.1180	37.2981
050503	1.5401	1.1870	37.7210	40.7324	43.1725	40.6369
050506	1.5155	1.2371	40.6534	42.3670	45.0150	42.6463

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)
050510	1.4186	1.5739	51.3143	54.8690	55.9804	54.0777
050512	1.4447	1.6174	50.1470	53.9292	55.7666	53.3326
050515	1.4010	1.1870	42.0106	45.0972	48.0055	45.0206
050516	1.6158	1.3602	45.6228	48.5267	51.7985	48.7239
050517	1.4708	1.2014	29.3694	29.8385	27.5098	28.8617
050523	1.3871	1.5852	46.9870	49.5029	53.7239	50.2344
050526	1.4939	1.2014	35.5457	*	36.5851	36.0168
050528	1.1577	1.1870	38.3051	41.9922	43.2272	41.1998
050531	1.1682	1.2014	28.4890	28.4921	31.0321	29.3108
050534	1.6008	1.1870	38.1892	39.7655	42.2995	40.1233
050537	1.6440	1.3602	41.5275	43.1765	45.7143	43.4984
050541	1.6420	1.6174	51.4545	55.2594	56.3250	54.3628
050543	0.7871	1.2014	32.8367	29.0470	31.0765	30.9541
050545	0.9027	1.2014	*	27.4889	*	27.4889
050547	1.0068	1.5765	*	*	*	*
050548	0.7480	1.2014	*	*	*	*
050549	1.6820	1.2318	40.6796	44.6715	46.9055	44.1190
050550	***	*	39.2163	*	*	39.2163
050551	1.3889	1.2014	37.6223	39.4047	42.1995	39.7582
050552	0.9442	1.2014	35.3468	38.6658	41.1129	38.3618
050557	1.6479	1.2145	39.2224	41.9292	43.9862	41.7818
050561	1.3989	1.2014	40.1567	43.1147	46.9061	43.3684
050567	1.5237	1.2014	39.0114	41.7247	46.3827	42.4553
050568	1.1903	1.1870	26.7733	28.7691	30.1066	28.6043
050570	1.7113	1.2014	40.6761	40.3411	42.9617	41.3454
050573	1.6162	1.1870	36.8561	38.0175	41.0430	38.7316
050575	1.5692	1.2014	22.1018	32.1046	33.5677	29.0034
050578	***	*	43.4917	*	*	43.4917
050580	1.3315	1.2014	35.0966	36.7968	33.1729	35.0881
050581	1.6333	1.2014	40.0909	41.9698	45.2862	42.4374
050583	***	*	40.5845	41.3920	*	40.9835
050584	***	*	31.9910	30.8650	*	31.4271
050586	1.6278	1.2014	31.1932	32.7348	32.8055	32.2348
050588	1.4763	1.2014	39.4251	39.0347	41.0596	39.8336
050589	1.2827	1.2014	37.2056	39.2646	40.8799	39.1760
050590	1.4972	1.3602	44.3382	50.0371	49.7024	48.1357

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)
050592	***	*	32.2376	*	*	32.2376
050597	1.4581	1.2014	32.8987	35.6567	37.5154	35.3942
050599	2.0012	1.3602	36.6146	38.9877	39.8060	38.5363
050601	***	*	43.2404	43.3329	46.0722	44.2165
050603	1.5047	1.2014	35.4809	37.4348	38.3795	37.1433
050604	1.6291	1.6379	49.6068	54.1687	55.6708	53.0785
050608	1.3872	1.1870	30.7280	28.3794	30.7173	29.9372
050609	1.4301	1.2014	43.4555	45.2475	49.1638	45.9869
050616	1.4949	1.2318	40.7388	45.2614	43.2974	43.0743
050618	0.9683	1.1870	34.9177	34.0584	35.2746	34.7478
050624	1.5075	1.2014	39.2553	40.2253	41.9140	40.5604
050625	1.8425	1.2014	44.8482	48.1826	49.2425	47.4957
050633	1.2030	1.2371	40.7383	41.1786	44.7408	42.2513
050636	1.4438	1.1870	35.4565	38.8844	39.6047	38.0071
050641	1.3049	1.2014	32.0508	33.1417	34.1809	33.1392
050644	1.0475	1.2014	33.2777	32.1513	32.5106	32.6114
050660	1.6423	*	*	*	*	*
050662	1.1129	1.6379	*	*	*	*
050663	1.3695	1.2014	17.7252	30.4117	33.0112	26.4009
050667	0.8006	1.4304	25.8460	30.1039	32.0592	28.9587
050668	1.0786	1.5739	52.7011	62.7714	65.4215	60.6289
050674	1.4993	1.3602	48.6880	51.3517	53.4793	51.2253
050677	1.5581	1.2014	41.8130	44.4567	47.7210	44.6363
050678	1.4527	1.2014	35.8411	38.3361	39.9117	38.1579
050680	1.4613	1.5739	39.0389	40.7514	44.0227	41.3391
050682	0.6944	1.1870	22.3903	22.4419	*	22.4133
050684	1.2570	1.1870	33.5915	33.0982	35.4639	34.0327
050686	1.3750	1.1870	42.1444	45.2231	47.9976	45.1103
050688	1.3358	1.6379	53.2741	54.5423	56.6393	54.8984
050689	1.5695	1.5852	48.9935	50.2942	53.7434	51.0570
050690	1.3287	1.5765	51.6179	55.1002	55.3785	54.0597
050693	1.4804	1.2014	42.8266	41.9594	44.4327	43.0953
050694	1.2375	1.1870	34.8486	33.8553	35.2375	34.6520
050696	2.5549	1.2014	39.4353	41.2315	44.0798	41.4921
050697	1.1148	1.3551	26.7600	29.0854	30.2691	28.7042
050701	1.3546	1.1870	37.2839	38.4382	42.7534	39.6120

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)
050704	1.1342	1.2014	32.2017	31.7051	32.1632	32.0280
050707	***	*	44.0254	49.4684	*	46.9800
050708	1.8358	1.1870	28.3074	34.4063	34.8867	31.9706
050709	1.6404	1.2014	29.5364	30.4570	28.8475	29.5804
050710	1.4205	1.1870	46.2533	51.1460	52.7980	50.0837
050714	1.5922	1.6379	42.9797	45.2746	47.4159	45.3955
050717	1.5965	1.2014	37.0875	42.2736	44.3341	41.4494
050720	***	*	32.1173	33.8712	34.7189	33.4568
050722	0.9563	1.1870	35.6741	35.2177	37.3247	36.1190
050723	1.5436	1.2014	42.1571	43.3875	47.0331	44.1760
050724	1.9468	1.1870	35.1020	35.5224	39.0498	36.5003
050725	0.9517	1.2014	28.8389	27.8565	*	28.3307
050726	1.6175	1.2145	30.6105	35.3964	36.4339	34.1895
050727	1.3740	1.2014	33.0932	29.0789	35.3222	32.5206
050732	2.3923	1.1870	34.3475	37.4333	37.9651	36.6924
050733	1.7727	1.3551	40.6320	44.7509	44.5669	43.2160
050735	1.4534	1.2014	36.6081	34.3859	34.2836	35.0705
050736	1.3576	1.2014	41.8938	38.0913	36.6162	38.8341
050737	1.7443	1.2014	38.0424	36.4535	38.0434	37.5147
050738	1.6053	1.2014	43.9259	40.3081	39.1201	41.0338
050739	1.6999	1.2014	57.2480	44.0540	40.0028	45.3846
050740	1.7415	1.2014	54.0370	44.8439	37.0942	43.5145
050741	***	*	51.1526	44.0305	*	47.5915
050742	1.6473	1.2014	39.2532	41.0036	44.3915	41.4597
050744	1.7380	1.2014	48.4951	56.5911	54.9014	53.1601
050745	1.4481	1.2014	42.5523	48.2903	48.8830	46.5702
050746	1.8123	1.2014	43.2015	46.3622	45.1902	44.9295
050747	1.8632	1.2014	44.5887	47.8242	47.3897	46.5459
050748	1.2527	1.2145	43.1008	50.6390	54.1187	49.3259
050749	1.3796	1.2318	28.2000	39.6030	41.4734	35.7662
050750	***	*	33.9915	*	*	33.9915
050751	3.5931	1.2014	29.5488	34.0436	36.5107	33.0514
050752	1.4901	1.2014	39.8035	41.3783	42.4637	41.1935
050754	1.2220	1.5582	*	56.3628	*	56.3628
050755	1.6182	1.2014	*	36.5212	36.5209	36.5210
050756	***	*	*	33.4951	*	33.4951
050757	1.7470	1.1870	*	*	42.3499	42.3499
050758	1.5779	1.2014	*	17.6509	27.8332	21.8692
050759	***	*	*	*	36.7451	36.7451
050760	1.3958	1.5852	*	*	*	*
050761	1.6126	1.2014	*	*	*	*
050762	1.4125	1.2014	*	*	*	*
050763	0.9992	1.2014	*	*	*	*
050764	1.6615	1.3551	*	*	*	*
050765	1.1291	1.1870	*	*	*	*
050766	1.5412	1.1870	*	*	*	*
060001	1.4318	1.0388	32.4226	32.5239	33.4988	32.8204
060003	1.5346	1.0388	31.8637	33.6264	34.9787	33.5087
060004	1.2485	1.0571	34.8428	34.5727	36.3180	35.2904
060006	1.2988	0.9661	27.6453	30.5664	30.7331	29.6321
060008	1.5166	0.9661	27.2071	26.0851	28.6887	27.3564
060009	1.6004	1.0571	34.0151	35.8398	36.9000	35.5938
060010	1.5399	0.9661	30.6424	33.5549	32.9213	32.3971
060011	1.5301	1.0571	34.4171	34.6239	36.6764	35.2344
060012	1.5328	0.9661	29.4365	29.6957	31.4778	30.2495
060013	1.6156	0.9661	28.0800	29.5100	30.9675	29.5274
060014	2.0318	1.0571	33.0366	35.6231	36.9316	35.1966
060015	2.1471	1.0571	36.3296	36.6824	38.2181	37.1123
060016	1.1827	0.9661	28.3055	30.0601	30.4173	29.6087
060018	1.0992	*	26.5788	*	*	26.5788
060020	1.6397	0.9661	26.7362	27.3823	29.0041	27.7427
060022	1.6431	0.9661	31.9376	32.0594	31.6889	31.8818
060023	1.6909	1.0388	32.7922	33.4798	34.9863	33.7713
060024	1.9110	1.0571	32.8206	36.1736	37.9178	35.6608
060027	1.5428	1.0388	31.6134	33.4869	33.6584	32.8740
060028	1.6913	1.0571	33.4966	35.8222	37.1127	35.5421
060030	1.4475	0.9661	31.2932	31.2752	32.9307	31.8560
060031	1.5069	1.0388	30.7381	32.0153	33.2264	32.0015
060032	1.6656	1.0571	34.6447	35.6500	37.4538	35.9166
060034	1.8224	1.0571	33.3656	34.6615	36.1664	34.7269
060036	1.1704	0.9661	20.9370	24.8220	25.3545	23.6411
060041	***	*	31.4739	*	*	31.4739

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)
060043	0.8976	0.9661	23.3908	19.9611	20.3264	21.2595
060044	1.2481	0.9661	28.9200	32.0455	32.7621	31.1824
060049	1.4153	0.9661	32.1589	34.5262	35.5319	34.0810
060054	1.4909	1.0134	24.6721	29.2998	32.8168	29.3582
060064	1.8838	1.0571	37.2407	34.7448	36.3062	36.0577
060065	1.4593	1.0571	34.9205	36.2377	37.7847	36.3148
060071	1.1608	0.9661	31.5388	32.1367	32.4472	32.0591
060075	1.4614	1.0134	35.8081	37.3019	40.0987	37.8393
060076	1.3290	0.9661	31.6044	31.5032	31.8354	31.6518
060096	1.8302	1.0388	38.2249	39.9302	42.6153	40.4317
060100	1.7950	1.0571	33.5356	35.7861	36.6761	35.3354
060103	1.4229	1.0388	33.7542	34.9964	36.7486	35.2080
060104	1.5478	1.0571	37.1434	37.4598	39.0546	37.9730
060107	2.0677	1.0571	30.3991	30.0308	30.5862	30.3538
060112	1.7503	1.0571	35.1308	36.4093	37.9883	36.6018
060113	1.5005	1.0571	35.2097	36.0794	38.0265	36.4941
060114	1.6645	1.0571	35.3056	37.1394	37.6507	36.8060
060115	0.9083	0.9661	*	*	*	*
060116	1.4913	1.0388	33.1547	36.3560	36.9037	35.6444
060117	1.3581	0.9661	28.3112	31.6734	31.2969	30.6135
060118	1.4926	1.0388	*	40.2136	39.9876	40.0879
060119	1.9646	0.9661	*	*	34.0792	34.0792
060121	2.1298	0.9757	*	*	38.3239	38.3239
060123	1.8589	1.0571	*	*	*	*
070001	1.6363	1.2501	37.9438	38.4864	39.2973	38.5767
070002	1.7996	1.2501	36.4269	36.6624	39.3448	37.4804
070003	1.1819	1.2501	36.0524	36.6553	37.6671	36.7808
070004	1.1875	1.2501	31.2115	34.3803	35.0996	33.5405
070005	1.6586	1.2501	36.5502	37.3430	38.3326	37.4196
070006	1.6560	1.2845	41.2165	41.9550	43.2538	42.1460
070007	1.4209	1.2501	37.0984	38.9830	40.3284	38.8203
070008	1.3351	1.2501	35.4969	34.0603	35.8128	35.1061
070009	***	*	36.6382	38.1380	*	37.4141
070010	1.6960	1.2845	38.6114	38.7345	41.3068	39.5937
070011	1.4801	1.2501	32.6835	33.7313	36.9431	34.4139
070012	1.4730	1.2501	33.2477	35.4738	37.5649	35.3823
070015	1.5810	1.2845	39.9249	42.4738	43.2814	41.8903
070016	1.5918	1.2501	34.1266	34.5418	36.2652	34.9865
070017	1.4503	1.2501	37.5855	38.1713	41.0035	38.9325
070018	1.4031	1.2845	42.4771	44.1370	45.8932	44.2064
070019	1.5997	1.2501	35.8618	37.0666	39.8708	37.6306
070020	1.3867	1.2501	35.6542	40.4989	40.6149	39.0606
070021	1.1794	1.2501	39.7793	41.9076	43.8574	41.8583
070022	1.7333	1.2501	41.4721	41.5553	43.2358	42.1286
070024	1.5050	1.2501	36.8997	38.6301	39.2473	38.2724
070025	1.7003	1.2501	36.1322	38.7067	38.9292	37.9067
070027	1.5868	1.2501	33.5979	35.7677	36.5191	35.3526
070028	1.5644	1.2845	40.9645	41.2950	42.0445	41.4502
070029	1.3443	1.2501	32.8504	35.4716	36.0372	34.8129
070031	1.3419	1.2501	30.5924	33.2618	33.5113	32.4873
070033	1.4782	1.2845	44.6717	46.5982	47.7651	46.3571
070034	1.5225	1.2845	42.4111	45.7694	44.0334	44.0840
070035	1.4095	1.2501	33.4047	38.2298	35.3319	35.6681
070036	1.7475	1.2501	43.6374	44.0756	46.7647	44.8853
070038	0.9441	1.2501	29.9516	33.5109	31.4424	31.4769
070039	1.0971	1.2501	32.7153	35.9137	36.2868	35.1252
070040	1.0743	1.2501	*	26.3824	30.5456	28.3394
080001	1.6907	1.0767	34.9507	37.4441	39.1800	37.2528
080002	***	*	33.0404	33.3472	35.2242	33.8881
080003	1.5403	1.0767	30.5132	29.0166	30.7067	30.1079
080004	1.6748	1.0615	34.3854	33.6190	35.0227	34.3410
080006	1.5520	1.0040	31.0327	30.7985	29.2377	30.3625
080007	1.7565	1.0723	33.4782	35.5425	37.3307	35.5114
090001	1.7104	1.0561	40.1658	38.3876	39.8098	39.3678
090003	1.3090	1.0561	34.4430	37.2088	37.7041	36.4784
090004	2.0589	1.0561	38.5681	39.9027	40.6172	39.7480
090005	1.3805	1.0561	35.2884	35.1327	36.9503	35.7913
090006	1.4341	1.0561	32.3654	32.5988	34.9901	33.3133
090008	1.5880	1.0561	36.6633	40.3260	41.7271	39.2631
090011	2.1681	1.0561	39.0111	39.5389	41.5636	40.0356
100001	1.6225	0.8872	27.8526	30.5213	30.2410	29.5864
100002	1.5581	1.0331	30.6668	33.1103	34.4002	32.7210

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)
100006	1.6837	0.9164	28.9769	29.2697	31.1056	29.8238
100007	1.6560	0.9164	30.3379	30.6689	32.9247	31.3295
100008	1.6404	1.0187	32.1679	32.3397	34.9309	33.1576
100009	1.6764	1.0187	30.0492	32.0145	33.5576	31.8694
100012	1.6726	0.9154	30.8626	30.2066	32.1013	31.0606
100014	1.5567	0.9164	27.4064	28.8679	32.2409	29.5960
100015	***	*	28.6825	29.9757	31.5898	30.0334
100017	1.6037	0.9164	29.8705	31.2313	32.0564	31.0917
100018	1.7857	0.9775	32.8642	34.2077	34.9488	34.0300
100019	1.7306	0.9300	31.4549	32.2496	34.2578	32.6900
100022	1.7695	1.0331	36.3355	40.4664	42.4835	39.7936
100023	1.6827	0.9062	27.1032	27.7860	27.8918	27.6048
100024	1.2216	1.0187	29.8918	31.5160	30.5515	30.6328
100025	1.8056	0.8429	27.1665	28.7604	29.6887	28.5808
100026	1.6151	0.8429	27.3044	28.5877	27.8336	27.9151
100028	1.4448	0.9300	28.7801	28.1509	31.9812	29.6720
100029	1.3707	1.0187	31.6006	33.2920	34.8115	33.2408
100030	1.4694	0.9164	26.3113	27.0977	30.8791	28.0842
100032	1.7391	0.9062	27.8942	29.3641	30.3211	29.1873
100034	1.8674	1.0187	28.9387	29.8997	29.6088	29.4876
100035	1.5772	0.9234	32.5593	31.2325	31.4854	31.7299
100038	1.6264	1.0331	32.8392	37.0928	37.2659	35.7794
100039	1.9693	1.0331	29.0236	32.6863	32.2387	31.3693
100040	1.7070	0.8872	28.3366	29.8029	29.6267	29.2500
100043	1.4166	0.9062	26.8417	29.1014	31.1938	28.9406
100044	1.5653	1.0725	34.3920	34.4743	41.7885	37.0048
100045	1.3103	0.9164	25.5621	27.8526	28.1617	27.2118
100046	1.5558	0.9062	27.7878	29.7844	30.9702	29.5983
100047	1.6811	0.9234	31.4072	31.8998	32.2005	31.8438
100048	0.9614	0.8429	21.7693	22.7260	23.5362	22.6808
100049	1.3320	0.8598	27.6316	26.9145	27.6986	27.4172
100050	1.2458	1.0187	23.5222	23.7419	24.5839	23.9530
100051	1.4875	0.9164	30.1492	28.7367	30.6429	29.8518
100052	1.4003	0.8598	25.1110	27.6591	28.4778	27.1102
100053	1.4162	1.0187	31.9268	33.6936	35.2505	33.5881
100054	1.4027	0.8732	30.9840	33.2237	36.2131	33.5025
100055	1.4759	0.9062	29.7027	28.5830	30.4261	29.5969
100057	1.4780	0.9164	27.7045	30.4258	30.4678	29.5602
100061	1.5789	1.0187	31.9174	33.9803	34.8450	33.5800
100062	1.7148	0.8548	26.3067	28.0821	29.2914	27.9099
100063	1.4087	0.9062	27.0769	29.5864	31.2456	29.3352
100067	1.5488	0.9062	27.5501	30.0555	31.5585	29.6761
100068	1.7784	0.9164	27.7707	28.5177	27.9984	28.0934
100069	1.8450	0.9062	29.0486	33.4008	32.7747	31.7234
100070	1.6892	0.9234	29.1117	27.1313	27.9944	28.0416
100071	1.3529	0.9062	25.1883	25.6870	27.8622	26.2736
100072	1.4518	0.9164	27.6947	28.6435	29.6852	28.7078
100073	1.7399	1.0331	31.0395	33.8783	33.7413	32.8932
100075	1.5788	0.9062	26.7571	29.2992	31.1968	29.0702
100076	1.2234	1.0187	24.0280	23.7078	26.3401	24.4927
100077	1.3992	0.9234	27.9783	28.0178	29.5920	28.5619
100079	1.5106	*	*	*	*	*
100080	1.6204	1.0331	31.0516	33.2091	35.4444	33.2117
100081	1.0281	0.8535	19.7406	17.2548	17.7199	18.2768
100084	1.6551	0.9164	30.6301	30.7165	35.1821	32.1800
100086	1.5751	1.0331	31.3187	33.0726	33.7019	32.7145
100087	1.8405	0.9234	32.1314	33.4104	33.2290	32.9242
100088	1.7052	0.8872	29.4952	30.3481	30.9109	30.2863
100090	1.4563	0.8872	28.9581	27.4996	28.1983	28.2131
100092	1.5558	0.9300	28.6782	29.1433	29.6062	29.1454
100093	1.7452	0.8429	23.4847	24.9505	25.8324	24.7515
100099	1.1448	0.8598	28.0688	28.2871	30.0306	28.8412
100102	1.0551	0.8429	29.0396	30.0754	28.5215	29.1924
100105	1.5943	1.0247	30.8936	31.5294	33.0669	31.8936
100106	1.0979	0.8429	25.6288	20.6449	26.2539	24.0761
100107	1.2712	0.9154	31.2954	30.9662	32.4252	31.5699
100108	***	*	22.8153	17.9561	17.5407	19.1436
100109	1.3854	0.9164	26.7380	29.1403	29.2450	28.3924
100110	1.6147	0.9164	30.3758	32.4083	32.8574	31.9053
100113	2.0648	0.9372	30.6037	30.9741	33.2370	31.6311
100114	***	*	32.3956	34.3630	*	33.3214
100117	1.1720	0.8872	30.0281	30.6894	31.4450	30.7451

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)
100118	1.4486	0.8429	28.3201	31.3833	28.6451	29.3957
100121	1.1958	0.8598	25.0320	20.0814	27.6256	24.2359
100122	1.2388	0.8732	27.6178	27.9970	28.5195	28.0525
100124	1.1993	0.8429	26.2329	28.2667	28.9262	27.8057
100125	1.2299	1.0187	33.3499	35.2588	37.2668	35.4517
100126	1.3809	0.9062	28.9164	30.3912	31.2068	30.1640
100127	1.6431	0.9062	27.0686	29.3856	31.1143	29.1782
100128	2.2037	0.9062	30.6202	29.6793	31.2260	30.5173
100130	1.3212	1.0331	29.5763	29.9727	29.8303	29.7958
100131	1.3800	1.0187	30.9614	32.2086	33.9556	32.3896
100132	1.3499	0.9062	27.6632	29.3380	30.9532	29.3463
100134	0.8526	0.8429	22.9635	24.7863	23.0664	23.5581
100135	1.6829	0.8950	29.8452	30.2093	34.2454	31.4426
100137	1.4023	0.8598	28.3000	27.8783	28.6739	28.2933
100139	0.9036	0.9372	21.4418	22.1683	21.4542	21.6815
100140	1.1241	0.8872	28.5485	29.7482	30.7120	29.6951
100142	1.2138	0.8429	26.8995	26.8829	25.1279	26.3134
100150	1.2062	1.0187	29.3711	33.0132	32.5758	31.6440
100151	1.9703	0.8872	31.3846	33.1725	34.9521	33.1531
100154	1.7005	1.0187	31.3640	32.3793	34.9871	32.9497
100156	1.1212	0.8429	28.3060	29.9029	31.1518	29.8242
100157	1.5825	0.9062	30.3359	30.4870	31.8560	30.8969
100160	1.1017	1.0187	32.3136	33.8433	35.2424	33.8495
100161	1.6418	0.9164	30.8984	32.6427	33.0203	32.1862
100166	1.6290	0.9234	31.9072	33.0019	34.8385	33.2076
100167	1.5548	1.0331	32.4740	34.8085	36.1305	34.4165
100168	1.7112	1.0331	28.0543	31.1427	32.5025	30.6375
100172	***	*	20.5518	*	*	20.5518
100173	1.7179	0.9062	30.2491	30.3599	30.9946	30.5301
100175	1.0188	0.8429	26.1723	26.8828	30.6933	27.8544
100176	1.7599	1.0331	35.5849	35.7433	37.0002	36.1141
100177	1.4618	0.9300	31.0085	31.3830	32.8452	31.7555
100179	1.7363	0.8872	30.5439	31.8790	33.3391	31.9259
100180	1.4792	0.9062	31.5485	32.3796	34.6774	32.8411
100181	1.4002	1.0187	26.0682	26.0880	26.4529	26.2174
100183	1.3902	1.0187	32.9893	31.6760	33.2426	32.6267
100187	1.4893	1.0187	31.6660	31.8020	34.2287	32.5953
100189	1.4419	1.0331	30.5516	32.8847	34.2405	32.5418
100191	1.3645	0.9062	30.9212	31.6024	33.7831	32.0662
100200	1.5295	1.0331	29.0731	32.5611	33.7020	31.7485
100204	1.6164	0.9372	29.9334	30.6252	31.4726	30.6885
100206	1.3259	0.9062	28.8625	30.4576	31.2623	30.2051
100209	1.6863	1.0187	29.0462	30.5582	32.8486	30.8020
100210	1.6173	1.0331	32.4566	33.3016	34.2951	33.3083
100211	1.2867	0.9062	28.8328	30.5902	31.6040	30.3665
100212	1.5679	0.8548	29.2500	30.5141	31.1332	30.3151
100213	1.5727	0.9234	30.2271	31.4309	33.1194	31.5983
100217	1.2905	1.0247	30.3325	33.5767	30.5594	31.4329
100220	1.6269	0.9154	30.8292	31.8393	33.1589	32.0025
100223	1.6223	0.8732	27.6775	28.6449	30.3707	28.8684
100224	1.3813	1.0331	29.2008	31.0307	33.6327	31.2118
100225	***	*	32.6906	31.8048	*	32.2587
100226	1.3734	0.8872	30.2857	30.8904	31.4325	30.8805
100228	1.4519	1.0331	31.0222	32.2672	34.6673	32.6399
100230	1.4348	1.0331	34.6133	35.9319	36.2218	35.6388
100231	1.6148	0.8429	28.3652	28.8912	29.8868	29.0343
100232	1.4309	0.9372	29.3797	30.3768	30.7904	30.1678
100234	1.3292	1.0331	29.7818	33.1508	35.3643	32.6846
100236	1.4897	0.9234	30.5719	31.4385	33.2953	31.8151
100237	***	*	33.9626	33.9696	34.7101	34.1867
100238	1.6561	0.9062	31.6353	32.8745	35.1822	33.2695
100239	1.5075	0.9062	30.3234	32.7150	33.9544	32.2850
100240	1.1030	1.0187	31.0951	35.3888	36.5932	34.4991
100242	1.5952	0.8429	27.8169	28.5034	29.7310	28.6967
100243	1.5542	0.9062	29.8323	31.4863	32.5183	31.3041
100244	1.4331	0.9154	29.8287	29.1611	30.4324	29.8033
100246	1.5614	1.0725	30.0467	32.5063	33.5431	32.0502
100248	1.5668	0.9062	32.4725	33.7659	36.0554	34.0847
100249	1.3514	0.9062	28.5117	29.7981	30.5194	29.6372
100252	1.2169	1.0247	29.1448	31.5631	33.8209	31.4840
100253	1.4998	1.0331	28.5617	29.4959	31.3031	29.8128
100254	1.5108	0.8950	28.5262	28.9095	30.8106	29.4270

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)
100255	1.3545	0.9062	29.5172	30.0466	31.9234	30.4937
100256	1.6224	0.9062	33.3936	34.6637	34.8261	34.2913
100258	1.6613	1.0331	35.2225	34.2862	36.3103	35.2863
100259	1.2922	0.9062	29.9294	32.2273	33.8174	31.9711
100260	1.5192	1.0725	29.4907	31.5667	33.8290	31.6734
100264	1.5444	0.9062	30.1980	31.5050	33.9236	31.9515
100265	1.4504	0.9062	26.6940	28.6915	30.9755	28.8501
100266	1.4224	0.8429	25.6382	26.4488	27.7396	26.6582
100267	1.2849	0.9234	30.6051	32.3955	33.7197	32.2092
100268	1.2089	1.0331	33.6225	33.5314	34.5818	33.9066
100269	1.4107	1.0331	28.3745	30.9572	33.5025	30.8885
100271	2.2229	*	*	*	*	*
100275	1.3264	1.0331	31.0487	31.5424	33.3902	32.0313
100276	1.3326	1.0331	31.7067	32.3992	34.3253	32.8333
100277	1.3799	1.0187	25.5926	27.0942	28.4922	27.0607
100279	***	*	31.1951	31.6691	33.9699	32.3430
100281	1.4063	1.0331	32.8840	36.3173	36.3630	35.2809
100284	1.1512	1.0187	21.4420	24.4155	25.5794	23.7587
100285	1.2393	1.0331	34.7999	36.2107	37.3307	36.2520
100286	1.6176	0.9775	26.5809	26.1494	32.3254	28.9983
100287	1.4754	1.0331	30.3085	32.3704	34.0864	32.1799
100288	1.7381	1.0331	32.9587	35.3363	36.0587	34.7714
100289	1.5892	1.0331	31.4727	31.7699	33.1977	32.2112
100290	1.2699	0.9164	29.7588	31.7110	32.8003	31.5879
100291	1.2805	0.9300	28.3780	28.3455	28.7294	28.4860
100292	1.4540	0.8535	28.5807	29.8156	30.8437	29.8351
100296	1.4038	1.0187	31.1475	31.8730	34.2695	32.5057
100298	0.8558	0.8950	21.9247	17.8678	19.4922	19.4575
100299	1.4576	0.9234	31.6840	31.5048	31.4272	31.5269
100300	***	*	33.1693	*	*	33.1693
100301	***	*	*	33.6261	*	33.6261
100302	1.1221	0.9164	*	27.9362	29.7254	28.8035
100303	***	*	*	*	24.9622	24.9622
100307	1.5052	0.8872	*	*	*	*
100308	1.8792	0.9062	*	*	*	*
100309	2.7432	0.9791	*	*	*	*
100310	3.4842	0.9791	*	*	*	*
100311	2.4626	0.9062	*	*	*	*
110001	1.4636	0.8635	27.6480	28.5465	29.6608	28.6422
110002	1.3129	0.9522	28.9013	32.2910	31.4257	30.8366
110003	1.3324	0.7747	25.0089	26.0330	25.4731	25.5072
110004	1.3418	0.8837	27.2528	26.8828	29.0636	27.7187
110005	1.4382	0.9522	29.6009	30.4924	30.9243	30.4115
110006	1.6178	0.9427	30.8495	32.2597	35.1927	32.8085
110007	1.7505	0.9051	28.0684	29.8618	31.7866	29.8999
110008	1.4810	0.9522	31.8387	33.5616	31.8752	32.4260
110010	2.4555	0.9522	33.9848	33.7073	37.5153	35.0454
110011	1.4340	0.9522	30.3534	32.2028	34.2320	32.3202
110015	1.0789	0.9522	30.5016	31.7245	32.6882	31.6687
110016	1.3214	0.8567	25.9209	26.3449	27.9562	26.7056
110018	1.4095	0.9522	30.9422	30.8295	32.9846	31.5752
110020	***	*	29.4641	30.4725	31.6434	30.4875
110023	1.4384	0.9522	29.2018	31.1890	31.5346	30.6932
110024	1.5142	0.8816	28.5660	30.7207	31.1155	30.1538
110025	1.4691	0.9304	31.8968	31.0532	32.4931	31.8044
110026	1.1774	0.7747	24.3863	25.6943	25.5664	25.1877
110027	1.0792	0.7747	25.6532	26.2689	26.5306	26.1257
110028	1.8270	0.9553	32.8706	34.0699	34.0936	33.6901
110029	1.8427	0.9522	30.1146	31.6425	33.3589	31.6865
110030	1.4738	0.9522	32.0275	33.2158	35.3940	33.6129
110031	1.2980	0.9522	30.7462	30.4811	31.6459	30.9681
110032	1.2257	0.7747	24.4968	23.1156	25.3818	24.3255
110033	***	*	32.7039	31.9373	*	32.3312
110034	1.8212	0.9553	29.6819	30.4053	34.4267	31.5542
110035	1.6957	0.9522	31.5737	31.8545	33.7788	32.4216
110036	1.9192	0.8816	28.4041	29.4915	30.6497	29.5199
110038	1.6353	0.7779	23.3669	24.2742	25.7731	24.5120
110039	1.3610	0.9553	28.4376	28.9594	29.2632	28.9093
110040	1.0861	0.9522	21.5762	21.1939	23.3824	22.0685
110041	1.4490	0.9427	27.6609	29.2068	29.6642	28.8354
110042	1.0433	0.9522	34.5137	34.0568	35.5964	34.7507
110043	1.8463	0.8816	30.3728	31.1628	31.4661	31.0195

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)
110044	1.1492	0.7747	27.0431	25.0449	25.2435	25.7950
110045	1.0749	0.9522	28.2232	31.6766	31.6049	30.4785
110046	1.1860	0.9522	28.6286	28.4212	30.3805	29.1772
110050	1.0846	0.8466	27.1533	29.2759	30.0664	28.8079
110051	1.1636	0.7747	22.1491	23.3866	25.5123	23.8373
110054	1.5235	0.9522	31.5798	27.9775	27.6520	29.0117
110059	1.1670	0.7747	24.9271	24.4436	25.3050	24.8819
110064	1.7636	0.9073	28.7296	30.0182	33.6965	30.7760
110069	1.4012	0.9194	30.6465	31.0168	29.6465	30.3950
110071	1.0603	0.7747	23.6499	22.6384	22.7875	23.0007
110073	1.1093	0.7747	23.0072	23.4570	24.6013	23.6838
110074	1.6250	0.9427	29.0310	30.4310	32.3204	30.6085
110075	1.3248	0.8816	26.1089	26.7302	27.8440	26.9306
110076	1.6273	0.9522	31.0661	30.4815	31.6781	31.0846
110078	2.1377	0.9522	32.0516	35.8457	34.2882	34.0288
110079	1.5730	0.9522	29.0905	28.9872	29.4465	29.1728
110082	2.0493	0.9522	31.1478	33.1144	35.7023	33.2768
110083	2.0957	0.9522	34.5798	34.7446	35.7641	35.0405
110086	1.3316	0.7747	23.4772	23.1298	23.3986	23.3340
110087	1.6146	0.9522	32.8029	33.9036	33.1476	33.2970
110089	1.0939	0.7747	26.0116	25.4960	27.7265	26.4111
110091	1.4186	0.9522	28.0637	29.4898	30.4024	29.2906
110092	1.1014	0.7747	22.8602	24.5262	28.2145	24.9154
110095	1.4911	0.8357	28.0480	31.2298	30.8040	30.0862
110100	0.9291	0.8568	20.0638	22.9014	22.3581	21.8865
110101	1.0901	0.7817	23.8601	25.5998	27.0075	25.5002
110104	1.2299	0.7747	22.2596	22.3707	25.3283	23.2665
110105	1.3045	0.8357	23.7752	24.6128	25.8193	24.7602
110107	1.9862	0.9483	31.5783	34.3508	32.6997	32.8859
110109	0.9841	0.7747	21.6019	22.5719	24.1100	22.7189
110111	1.2997	0.9553	27.6501	25.7188	26.1187	26.4741
110112	1.0053	0.8357	24.2935	23.2426	23.8772	23.7850
110113	0.9056	0.9553	22.0472	24.2980	23.8663	23.3780
110115	1.8784	0.9522	33.3902	34.4864	35.7053	34.5468
110121	1.0235	0.7747	24.5653	27.4406	28.0014	26.6713
110122	1.5890	0.8757	26.3071	28.0334	29.1487	27.8263
110124	0.9766	0.7747	24.8552	28.7544	30.1853	27.9291
110125	1.3181	0.9194	26.5006	29.4103	30.3256	28.6930
110128	1.3499	0.7747	24.5284	27.1987	29.5380	27.0076
110129	1.6241	0.9073	29.7332	26.8229	29.6639	28.7871
110130	0.8616	0.7747	21.7089	21.0352	21.1104	21.2759
110132	0.9942	0.7747	21.6039	22.3816	23.0238	22.3418
110135	1.4233	0.7747	25.1027	25.6594	25.4248	25.3863
110142	0.9519	0.7939	22.2164	21.2836	23.4206	22.2516
110143	1.4910	0.9522	30.9621	31.3623	33.8210	32.0558
110146	0.9949	0.9304	30.1181	32.7307	33.2545	32.0684
110150	1.3556	0.9522	27.7920	28.7549	25.9661	27.3881
110153	1.2669	0.9194	30.5108	30.2843	29.0355	29.9173
110161	1.6539	0.9522	32.0002	32.9894	34.2368	33.1032
110163	1.5743	0.9051	29.5693	30.7798	31.5932	30.6938
110164	1.7796	0.9483	31.2830	32.7865	34.6834	32.9557
110165	1.5814	0.9522	28.7925	28.4324	29.6474	28.9456
110168	1.8987	0.9522	30.8750	31.8921	32.9678	31.9123
110172	***	*	33.0452	34.0243	*	33.5073
110177	1.9707	0.9553	30.5526	31.9338	34.1095	32.1836
110183	1.3243	0.9522	29.6622	32.0200	32.3919	31.3707
110184	1.2816	0.9522	30.2920	30.8380	33.5243	31.6098
110186	1.3175	0.9073	29.6503	32.0599	32.7123	31.3877
110187	1.2145	0.9522	31.0164	27.6729	30.2035	29.5453
110189	1.0743	0.9522	27.4207	28.9465	30.6904	29.0577
110190	1.0617	0.8516	29.4198	28.7747	35.0662	30.9649
110191	1.4803	0.9522	28.7505	30.0142	32.1567	30.3001
110192	1.5471	0.9522	31.6627	32.6403	33.8910	32.7853
110194	0.8287	0.7747	20.5267	23.2382	22.8678	22.2186
110198	1.4509	0.9522	34.0050	33.2450	34.3539	33.8687
110200	2.3051	0.9073	29.4633	29.6256	31.9890	30.3293
110201	1.5909	0.9483	33.4292	35.8335	36.5328	35.2852
110203	1.0033	0.9522	32.0594	33.0119	39.2016	34.2391
110205	1.1254	0.8213	26.1973	25.5319	25.5761	25.7605
110209	0.8544	0.7747	22.4549	21.6681	24.1906	22.7930
110212	1.1580	0.8108	*	23.4398	24.7776	24.1182
110215	1.5772	0.9522	30.1793	31.2779	34.0399	31.9365

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)
110219	1.5092	0.9522	33.4481	34.8875	35.5762	34.5954
110225	1.4407	0.9522	28.9773	29.6272	31.3077	30.0852
110226	1.2984	0.9522	32.1840	30.2150	31.1927	31.1833
110229	1.5914	0.9522	*	*	30.3527	30.3527
110230	1.4559	0.9522	*	*	35.3708	35.3708
110231	2.6459	0.9427	*	*	*	*
120001	1.9654	1.1601	39.0371	39.2838	41.7792	40.0687
120002	1.3903	1.1343	37.7287	38.3420	40.8409	39.0677
120004	1.4516	1.1601	32.5164	33.3874	34.8746	33.5332
120005	1.4037	1.1343	35.1996	38.2915	41.0269	38.1959
120006	1.3827	1.1601	35.7089	37.6360	38.8046	37.4353
120007	1.6959	1.1601	35.0193	34.8231	36.1131	35.3230
120010	2.0707	1.1601	34.3371	37.3680	38.2981	36.3749
120011	1.6395	1.1601	43.7527	45.9848	46.1117	45.3381
120014	1.3862	1.1343	34.2127	38.1372	37.5286	36.5840
120019	1.1857	1.1343	36.1879	37.4564	40.6301	38.1365
120022	1.8805	1.1601	34.9048	35.3877	38.3854	36.2577
120026	1.4967	1.1601	35.8413	38.2128	40.8015	38.3631
120027	1.4876	1.1601	31.8177	32.7112	36.4744	33.4982
120028	1.3976	1.1343	34.6354	34.7783	35.3936	34.9845
130002	1.4862	0.9024	24.3501	26.4728	25.9182	25.6059
130003	1.7141	0.9611	29.8793	31.4275	32.0470	31.1256
130006	1.7583	0.9258	29.0504	30.0002	31.6976	30.3248
130007	1.8904	0.9258	31.2268	33.4536	33.5710	32.8352
130013	1.4315	0.9258	33.8928	33.6160	34.7929	34.1015
130014	1.2836	0.9258	28.2831	29.1200	31.1556	29.5129
130018	1.7913	0.9628	30.2047	31.8735	34.0663	32.0669
130024	1.2438	0.8237	25.3197	24.4757	27.9223	25.9215
130025	1.2892	0.7550	23.8592	24.2424	25.4804	24.5574
130028	1.7322	0.9332	29.3374	30.5090	32.7403	30.8796
130049	1.6650	1.0332	29.7211	30.8293	32.3180	31.0094
130062	***	*	28.3419	38.1416	38.1979	35.1501
130063	1.5471	0.9258	27.7697	28.8897	30.6316	29.0576
130065	2.0187	0.9628	25.8998	29.4957	31.7080	28.7341
130066	2.3072	0.9535	28.1502	29.3049	30.2120	29.2277
130067	3.0407	0.9628	26.8285	28.6474	*	27.6699
130068	***	*	*	25.8399	*	25.8399
130069	2.8776	0.9258	*	*	*	*
130070	2.9727	0.9258	*	*	*	*
140001	1.2495	0.8659	23.2233	23.7481	24.5596	23.9078
140002	1.5362	0.9014	29.1097	29.6312	30.6484	29.8043
140007	1.5429	1.0489	32.4449	34.2607	34.3990	33.7432
140008	1.5089	1.0505	32.7618	33.2563	33.8440	33.2674
140010[3]	1.5525	1.0505	39.3727	39.7245	41.6675	40.3248
140B10[3]	***	1.0683	39.3727	39.7245	41.6675	40.3200
140011	1.1871	0.8338	26.2135	27.0019	27.8976	27.0768
140012	1.1826	1.0376	31.9613	33.0198	33.9579	33.0373
140013	1.3956	0.9243	26.4199	28.2787	29.7570	28.1731
140015	1.3818	0.8913	25.2504	25.8304	27.2769	26.1214
140018	1.4659	1.0505	31.5624	31.2535	32.8742	31.9223
140019	0.9025	0.8338	22.2907	22.9179	22.1757	22.4617
140026	1.2390	0.8640	28.1718	28.5497	28.8938	28.5443
140029	1.6147	1.0489	34.8938	37.7285	39.2884	37.4095
140030	1.6091	1.0489	32.1135	32.8927	34.5289	33.1528
140032	1.2724	0.8913	28.5242	28.4605	28.8023	28.6013
140033	0.8477	1.0683	31.4347	32.3417	37.3123	32.3449
140034	1.2373	0.8913	26.7250	27.6121	29.4202	27.8948
140040	1.2933	0.9133	28.5016	30.5814	29.5788	29.5205
140043	1.2977	0.8615	31.3754	34.4429	36.6311	34.1700
140046	1.5473	0.8913	25.7925	26.8384	27.7881	26.8001
140048	1.3808	1.0505	31.6290	34.4373	35.6118	33.9217
140049	1.5889	1.0505	32.0239	33.6104	35.1271	33.5565
140051	1.6022	1.0505	32.6517	32.7898	35.9623	33.8119
140052	1.4729	0.9014	26.7916	27.7932	28.3548	27.6315
140053	1.8431	0.8903	29.9487	32.7126	32.7047	31.7534
140054	1.5563	1.0505	34.5369	36.9786	37.5257	36.3798
140058	1.2163	0.8903	26.5671	28.6945	29.4562	28.2816
140059	1.1060	0.9014	22.8597	24.6248	27.1264	24.8675
140062	1.4327	1.0505	36.6718	38.3407	40.0331	38.3858
140063	1.5742	1.0505	31.1266	34.4732	34.2855	33.3225
140064	1.2440	0.9133	26.6249	28.5964	28.7145	28.0090
140065	1.5255	1.0505	32.4661	34.3988	34.8541	33.9252

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140066	0.8358	0.9014	23.6304	24.3856	25.8782	24.6256
140067	1.8100	0.9243	30.6911	31.9470	33.6451	32.1163
140068	1.3473	1.0505	31.3463	32.8724	34.3293	32.8225
140075	***	*	33.6872	34.9376	37.0576	35.1198
140077	1.1765	0.9014	22.5074	24.2006	27.9884	24.7797
140080	1.6004	1.0505	30.3788	33.0275	33.9533	32.4493
140082	1.6828	1.0505	32.0562	33.4686	33.5547	33.0474
140083	1.0840	1.0505	26.1639	29.5034	26.0249	27.1366
140084	1.4066	1.0683	31.3307	32.1286	34.0772	32.4874
140088	2.0925	1.0505	34.4137	36.6991	39.5615	36.8342
140089	1.1697	0.8338	26.6955	27.5295	28.0413	27.4273
140091	1.7821	1.0110	29.7381	33.7851	35.7373	33.1400
140093	1.3604	0.9673	31.2973	29.3377	33.9389	31.5436
140094	0.7328	1.0505	28.8621	28.0819	31.7623	29.3412
140095	1.3861	1.0505	29.9626	35.7876	34.5133	33.4421
140100	1.5029	1.0683	37.3044	39.0405	53.2727	43.9747
140101	1.2867	1.0489	31.0070	32.4260	33.9429	32.5006
140103	1.1752	1.0505	25.3630	26.4236	27.1870	26.3280
140105	***	*	30.7154	*	*	30.7154
140110	1.0816	1.0376	31.3486	33.7263	37.0508	34.0404
140113	1.5438	1.0110	31.6191	33.2262	34.9580	33.3307
140114	1.5369	1.0505	31.1412	31.7038	31.9854	31.6099
140115	1.1726	1.0505	26.2606	30.2062	33.3997	29.8386
140116	1.4871	1.0505	34.2519	35.6726	37.3698	35.8062
140117	1.6529	1.0505	28.5809	34.6766	33.8357	32.2615
140118	1.5189	1.0505	33.8168	34.9352	35.7791	34.8464
140119	1.9388	1.0505	34.6543	35.5146	39.1791	36.4468
140120	1.2850	0.9243	26.2418	27.0681	28.1479	27.1792
140122	1.6620	1.0489	32.4750	34.2512	35.7211	34.1628
140124	1.2545	1.0505	38.8976	39.9267	42.6170	40.3589
140125	1.1748	0.9014	27.6352	28.3533	30.1414	28.6658
140127	1.5604	0.9519	29.3352	30.9124	32.7895	30.9540
140130	1.3285	1.0683	34.9907	35.8275	36.5289	35.7840
140133	1.3550	1.0505	32.8941	34.0222	33.5156	33.4781
140135	1.4489	0.9108	25.9057	26.6854	27.2890	26.6111
140137	1.0866	0.9014	*	27.0616	26.9536	27.0077
140143	1.1048	0.8338	27.0312	27.2878	28.8780	27.7632
140145	1.3204	0.9014	26.9344	28.3622	29.2094	28.2011
140147	1.0814	0.8338	22.1035	22.6508	23.5493	22.7821
140148	1.7060	0.8903	28.9471	30.1467	30.0579	29.7409
140150	1.6603	1.0505	39.0316	41.6125	41.9981	40.8995
140151	0.9472	1.0505	27.3552	28.0758	27.9178	27.7883
140152	***	*	32.2803	*	*	32.2803
140155	1.3206	1.0518	35.0825	36.2360	42.9303	38.0726
140158	1.4480	1.0505	32.0137	31.7570	32.5477	32.1263
140160	1.3230	0.9824	28.9043	30.0100	29.7248	29.5545
140161	1.4829	1.0376	28.8150	33.5158	34.2430	32.1513
140162	1.6404	0.9519	33.0995	33.2372	34.3257	33.5587
140164	1.7410	0.8401	27.3133	27.5981	28.8799	27.9473
140166	1.2438	0.9108	27.6725	27.5406	28.8294	28.0427
140167	1.1637	0.8338	24.2749	21.2479	26.4139	23.8753
140172	1.4264	1.0505	33.4616	36.8394	37.7857	35.9966
140174	1.6817	1.0489	33.9382	35.1535	37.3959	35.5471
140176	1.2563	1.0505	33.2235	34.3901	35.2444	34.3183
140177	1.0534	1.0505	26.0727	28.0720	30.3681	28.2108
140179	1.4032	1.0505	31.3624	30.6997	31.6563	31.2396
140180	1.4341	1.0505	29.8009	31.4683	33.1794	31.5663
140181	1.2767	1.0505	27.5414	29.0862	28.5796	28.3990
140182	1.5270	1.0505	26.4103	34.4971	35.0820	31.5363
140184	1.4579	0.8338	27.5858	28.2155	30.8775	28.8685
140185	1.4880	0.9014	27.9433	29.7742	31.1133	29.6199
140186	1.5823	1.0518	32.8063	32.5128	33.6464	32.9973
140187	1.5586	0.9014	26.9265	29.2345	29.0123	28.4350
140189	1.2512	0.8338	29.1371	25.9192	29.7421	28.2272
140191	1.4166	1.0505	29.7684	31.4076	32.4731	31.2532
140197	1.0537	1.0505	24.8715	26.9930	26.0594	25.9589
140200	1.5345	1.0489	31.3712	33.2897	34.0840	32.9096
140202	1.4834	1.0683	34.3789	38.4323	37.4182	36.7740
140206	1.1584	1.0505	31.1406	31.5212	27.6394	29.9639
140207	1.2953	1.0505	31.6818	25.8073	32.4844	29.9192
140208	1.8222	1.0505	26.1749	26.2434	36.5596	29.1075
140209	1.6452	0.9243	28.8774	31.5349	31.8639	30.7282

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)
140210	1.0405	0.8338	22.2512	24.1193	24.7355	23.7491
140211	1.4102	1.0489	34.5917	36.0400	37.0927	35.9429
140213	1.2807	1.0489	33.3932	33.6351	35.1982	34.1062
140217	1.5985	1.0489	33.2172	34.8475	36.7887	35.0324
140223	1.6066	1.0505	34.6997	36.6437	38.4066	36.5708
140224	1.4303	1.0505	30.2241	34.4001	32.1563	32.1521
140228	1.4921	1.0002	28.7462	30.7381	33.1695	30.9903
140231	1.5719	1.0489	35.6724	36.3601	38.2995	36.8480
140233	1.7853	1.0002	32.3376	35.7752	36.3849	34.8777
140234	1.0863	0.8640	25.7660	26.9670	27.9357	26.8993
140239	1.7231	1.0002	33.7264	35.6391	35.6986	35.0222
140240	1.4344	1.0505	28.0986	32.9491	34.4684	31.9056
140242	1.6355	1.0489	36.8032	40.7474	41.8106	39.8939
140250	1.2990	1.0505	32.9414	33.7382	35.9520	34.1573
140251	1.4663	1.0505	29.5941	31.5378	33.9106	31.6509
140252	1.5144	1.0505	36.1531	37.6031	38.5971	37.4867
140258	1.7431	1.0505	34.5696	34.9198	36.4972	35.3477
140275	1.4119	0.8615	26.7394	26.7114	28.4065	27.3085
140276	2.0654	1.0505	32.7073	33.1620	35.5826	33.8452
140280	1.4890	0.8615	26.9835	28.0388	28.9805	28.0214
140281	1.7722	1.0505	37.5700	38.6663	40.2998	38.8908
140286	1.2278	1.0489	32.2246	38.2039	37.1381	35.9381
140288	1.6334	1.0489	32.5472	34.1167	37.2904	34.6380
140289	1.3772	0.9014	26.0872	26.7573	27.9721	26.9777
140290	1.5455	1.0505	35.9679	34.5766	36.0868	35.5278
140291	1.6451	1.0683	32.7884	34.2987	37.6788	34.9816
140292	1.3397	1.0489	32.4496	32.9675	34.8143	33.4325
140294	1.2039	0.8338	26.9789	27.4105	29.1269	27.8152
140300	1.0783	1.0505	37.4508	35.5837	50.8341	41.0114
140301	0.9779	1.0505	35.9742	*	*	35.9742
140303	2.2113	1.0505	33.0359	31.4718	27.9248	30.4351
140304	1.4263	1.0489	*	*	*	*
150001	1.2764	0.9508	32.9804	32.5348	32.6196	32.7114
150002	1.6234	1.0376	28.1076	28.3271	29.6877	28.6811
150003	1.7222	0.9207	29.3660	30.1317	33.7045	30.8976
150004	1.5661	1.0376	31.7867	34.4889	35.7042	34.0018
150005	1.3511	0.9508	31.6090	32.6541	33.1149	32.4670
150006	1.4802	0.9440	28.3403	29.7289	30.6284	29.5965
150007	1.5994	0.8975	31.0384	32.4836	32.2902	31.9585
150008	1.4456	1.0376	29.1492	30.9426	33.9840	31.5683
150009	1.5710	0.8817	26.1517	25.9625	26.7864	26.3065
150010	1.6352	0.8975	28.2616	32.8116	30.3846	30.4151
150011	1.3841	0.9508	27.7870	27.8089	29.9406	28.4962
150012	1.5535	0.9839	31.6762	32.0116	33.6473	32.4563
150015	1.4932	0.9351	30.2516	32.6995	36.4114	32.8802
150017	1.7290	0.9252	27.1262	27.4538	31.1509	28.5768
150018	1.6443	0.9440	30.0928	30.9511	32.3246	31.1260
150021	1.7703	0.9252	31.1158	33.1505	34.1205	32.7882
150022	1.0676	0.8609	26.9525	29.7752	29.6949	28.8102
150023	1.5976	0.9508	30.3667	30.8457	32.8811	31.3893
150024	1.6680	0.9508	30.6154	32.1844	32.4340	31.8072
150026	1.2688	0.9440	31.9397	33.1225	34.1026	33.0877
150029	***	*	31.0692	32.1154	34.7437	32.5688
150030	1.1399	0.9508	31.1986	34.5137	33.5330	33.0650
150033	1.4780	0.9508	32.9469	31.7314	32.8742	32.5221
150034	1.5129	1.0376	30.0048	30.9961	32.0634	31.0330
150035	1.4857	0.9088	29.2039	27.9432	31.3057	29.4545
150037	1.4116	0.9508	30.4640	32.2960	34.2630	32.3680
150038	1.2551	0.9508	31.9552	32.2545	32.5514	32.2573
150042	1.3233	0.8684	25.2456	25.2218	26.7144	25.7169
150044	1.5944	0.8817	25.9284	26.6389	28.1592	26.9137
150045	0.9713	0.8358	29.4323	30.0052	30.9186	30.1018
150046	1.5593	0.9207	27.6228	29.7184	30.9620	29.3843
150047	1.6689	0.9252	27.1847	27.9365	31.6474	28.8986
150048	1.5145	0.9589	29.5588	30.5008	32.4026	30.8321
150051	1.6271	0.9508	30.3764	31.2746	32.2623	31.3266
150056	2.0215	0.9508	30.5777	30.8461	32.3999	31.2935
150057	1.8617	0.9508	29.2358	30.4490	32.1266	30.5833
150058	1.6714	0.9839	31.7558	32.4036	35.0215	33.0637
150059	1.4935	0.9508	36.2570	30.4189	32.7364	32.9226
150061	1.1637	0.8358	23.2427	24.7808	25.5337	24.5376
150064	1.1633	0.9508	28.9430	29.7898	31.2162	29.8684

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)
150065	1.2812	0.9508	30.7970	31.7556	30.5732	31.0251
150069	1.1856	0.9589	27.0740	28.6514	29.6604	28.4841
150072	1.1231	0.8451	23.0619	24.6596	25.9231	24.5275
150074	1.4197	0.9508	29.4135	31.6043	32.2665	31.1342
150075	1.1147	0.9252	26.5987	27.1412	29.3233	27.5810
150076	1.3188	0.9440	30.2972	29.4643	30.9744	30.2379
150082	1.5964	0.8358	28.1302	28.0003	28.9091	28.3707
150084	1.8928	0.9508	35.0288	35.4818	35.6613	35.4120
150086	1.1942	0.9589	27.2580	28.8279	29.7380	28.6105
150088	1.3132	0.9508	30.2396	31.9171	33.4837	31.8580
150089	1.7163	0.8693	26.7290	28.0389	28.6116	27.7647
150090	1.4939	1.0376	30.9274	33.6812	32.6443	32.3771
150091	1.1504	0.9252	33.0421	32.9027	32.9035	32.9485
150097	1.2299	0.9508	29.4797	29.9967	31.3570	30.2952
150100	1.6908	0.8358	27.6339	30.0246	30.5761	29.4353
150101	1.0091	0.9252	31.6031	32.5860	33.5763	32.5984
150102	1.0478	0.9088	25.4717	30.4952	30.6827	28.7313
150104	1.2531	0.9508	30.8984	31.2245	32.6342	31.6510
150109	1.6020	0.9207	29.0076	31.0757	31.1513	30.3463
150112	1.5048	0.9508	31.7966	32.0659	33.0802	32.3311
150113	1.2748	0.9508	26.9098	29.0485	31.1256	29.0321
150115	1.3849	0.8358	22.3571	25.0221	22.3893	23.2169
150125	1.5510	1.0376	30.7113	31.6959	31.3215	31.2467
150126	1.3388	1.0376	32.6488	34.5086	34.8672	34.0126
150128	1.4381	0.9508	31.1071	30.7549	33.5372	31.8206
150129	1.4581	0.9508	32.9629	36.4709	35.7480	35.1611
150133	1.1372	0.9440	23.0662	25.1415	27.9640	25.3957
150134	***	*	27.3983	30.4440	*	28.8978
150146	1.1222	0.9409	31.8757	32.9491	33.5213	32.8174
150147	***	*	28.9269	28.9204	26.2549	28.1291
150149	0.9508	0.8358	25.3350	26.4595	28.5345	26.8740
150150	1.3103	0.9252	26.5984	26.5020	30.8707	28.0109
150153	2.2954	0.9508	37.3948	38.6948	40.7183	38.9618
150154	2.2826	0.9508	30.5775	32.3383	33.4160	32.1329
150157	1.7623	0.9508	32.9167	35.4134	36.4511	34.9906
150158	1.3123	0.9508	30.4355	31.5245	33.9082	32.0780
150159	***	*	27.5595	*	*	27.5595
150160	2.0703	0.9508	27.6375	31.2957	35.6845	31.9411
150161	1.6991	0.9508	*	32.3409	32.7850	32.5700
150162	1.8807	0.9508	*	32.2317	34.2999	33.2473
150163	1.0317	0.8817	*	26.0437	25.0118	25.4832
150164	1.2919	0.9241	*	*	34.3570	34.3570
150165	1.4820	1.0376	*	*	29.7883	29.7883
150166	0.9623	1.0376	*	*	23.3078	23.3078
150167	2.3686	0.9252	*	*	*	*
150168	2.1247	0.9252	*	*	*	*
150169	1.6356	0.9508	*	*	*	*
150170	1.3876	1.0376	*	*	*	*
150172	1.6329	0.8817	*	*	*	*
150173	1.6384	0.9207	*	*	*	*
150174	0.9714	0.9088	*	*	*	*
150175	2.3255	0.8358	*	*	*	*
150176	2.7334	0.8817	*	*	*	*
160001	1.3311	0.9481	25.8686	27.4207	27.9443	27.0734
160005	1.2769	0.8469	24.8597	25.6204	26.4045	25.6930
160008	0.9769	0.8469	24.1282	24.3704	24.4477	24.3149
160013	1.2219	0.8661	25.5162	26.6913	28.1863	26.7367
160016	1.5478	0.9230	26.6537	27.9879	28.7996	27.8136
160024	1.5796	0.9481	32.4253	32.7762	34.4334	33.1982
160028	1.4350	0.9507	29.8343	32.4639	33.7759	32.0895
160029	1.5442	0.9507	32.2035	33.7679	34.1881	33.3857
160030	1.3905	1.0012	30.4779	32.0333	35.0814	32.5822
160032	0.9942	0.8818	28.5645	29.0326	31.8052	29.8289
160033	1.6046	0.8615	27.4810	27.6537	29.9638	28.3723
160040	1.4565	0.8469	28.2982	27.9810	28.9782	28.4158
160045	1.7963	0.8759	28.1681	30.0063	30.1529	29.4737
160047	1.2816	0.9507	29.4286	31.2897	32.5374	31.0801
160057	1.5524	0.9379	27.7969	28.3640	29.9056	28.7087
160058	2.0933	0.9507	29.8975	31.2742	33.2290	31.5144
160064	1.4740	0.9100	33.6082	32.7787	33.3339	33.2324
160067	1.4190	0.8469	26.7679	27.2055	27.9842	27.3206
160069	1.5388	0.8523	28.4081	29.0981	30.1711	29.2226

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160079	1.5326	0.8759	28.5034	29.8338	31.5805	30.0004
160080	1.2455	0.8615	27.8745	27.4136	29.4664	28.2502
160082	1.8108	0.9481	31.7508	34.0609	34.3109	33.3846
160083	1.7250	0.9481	29.9489	31.0514	33.2469	31.4485
160089	1.3913	0.8469	23.9194	25.0810	26.2920	25.0584
160101	1.1089	0.9481	26.8515	27.1889	27.7494	27.2713
160104	1.6136	0.8615	27.0538	27.8486	29.6153	28.2427
160110	1.5439	0.8469	29.9094	30.8876	32.2683	31.0206
160112	1.2738	0.8469	26.1721	26.7136	28.5399	27.1627
160117	1.4386	0.8523	24.3326	28.8434	29.5391	27.4129
160122	1.1901	0.8469	25.3192	26.6212	27.6183	26.5313
160124	1.0341	0.8469	25.5048	27.2937	27.7817	26.8749
160146	1.5275	0.8924	25.1834	27.1213	27.6964	26.6850
160147	1.1959	0.9230	33.6394	37.2058	33.7891	34.8350
160153	1.7431	0.8924	30.4356	32.1357	33.9158	32.1388
160155	***	*	*	30.2301	*	30.2301
160156	1.6040	0.8759	*	*	*	*
170001	1.1336	0.7987	24.5942	26.2914	27.4893	26.1336
170006	1.3107	0.8413	28.3527	30.5591	29.7014	29.5398
170009	1.1982	0.9510	32.2847	29.3342	35.8796	32.4438
170010	1.2280	0.7987	28.1802	28.6734	28.0200	28.2848
170012	1.6238	0.7987	28.7878	30.0388	31.3253	30.0668
170013	1.8476	0.8846	28.3051	29.6511	29.3109	29.1021
170014	1.0892	0.9510	25.8165	27.2909	28.6614	27.2555
170016	1.7045	0.9092	28.6817	31.9998	32.2124	30.9357
170017	1.1853	0.8815	29.1463	29.5447	30.5514	29.7607
170020	1.5234	0.8712	25.0561	26.1258	27.5236	26.2649
170023	1.4396	0.7987	24.8827	24.9932	23.5925	24.4624
170027	1.4459	0.7987	24.1133	24.6748	28.0584	25.5270
170033	1.2736	0.8712	25.0404	26.9830	28.5392	26.8282
170039	1.0418	0.8815	23.5975	24.1339	25.9923	24.5999
170040	1.9930	0.9510	30.0828	33.3813	34.7516	32.6350
170049	1.5816	0.9510	31.8595	34.8212	36.0419	34.2779
170058	1.0032	0.9510	28.1330	28.6239	28.3918	28.3840
170068	1.1495	0.8396	23.8509	25.6803	26.5966	25.3761
170074	1.1194	0.7987	24.8871	26.7280	27.0960	26.2409
170075	0.8374	0.7987	21.1965	20.9091	23.3332	21.8094
170086	1.5306	0.9092	28.5260	30.0102	31.6755	30.1214
170094	0.9016	0.7987	17.1719	26.4808	26.5156	22.5975
170103	1.4110	0.8815	25.5671	26.2628	27.2902	26.3960
170104	1.5054	0.9510	29.7793	31.7058	33.9818	31.8221
170105	1.0539	0.7987	23.4332	24.4249	25.3817	24.4220
170109	1.2001	0.9510	29.0197	33.0257	35.5875	32.6017
170110	0.9742	0.7987	24.7927	26.7359	27.8029	26.4646
170120	1.5992	0.7987	23.5287	24.9819	25.5421	24.7141
170122	1.7938	0.8815	29.6337	31.0839	31.6921	30.8178
170123	1.8214	0.8815	28.7627	29.1591	30.2071	29.3829
170133	1.0783	0.9510	25.7129	27.6138	29.6829	27.6799
170137	1.5460	0.7987	26.8029	28.6556	29.7194	28.4166
170142	1.4422	0.8903	25.5567	26.4060	27.8126	26.6231
170145	1.2223	0.7987	25.3745	26.5981	26.7870	26.2817
170146	1.6495	0.9510	31.7023	31.6451	33.8515	32.3696
170147	***	*	21.4581	*	*	21.4581
170150	1.1460	0.8130	22.0265	22.2379	22.4145	22.2242
170166	0.9627	0.7987	24.1079	24.4570	25.1544	24.5738
170175	1.2714	0.8712	31.7600	30.1456	32.3710	31.4384
170176	1.6710	0.9510	30.1135	31.4048	32.9852	31.5085
170182	1.4837	0.9510	30.3805	32.3903	32.5452	31.7959
170183	2.0144	0.8815	27.7207	27.5559	27.2238	27.4855
170185	1.3885	0.9510	29.3226	31.0813	31.8914	30.8229
170186	2.5662	0.8815	30.7673	36.3546	37.5515	34.8706
170187	1.8179	0.7987	24.6419	26.2236	27.0023	25.9973
170188	2.0192	0.9510	33.7247	34.0134	35.3922	34.4575
170190	1.0539	0.7987	27.3041	28.7392	29.4515	28.5185
170191	1.6762	0.7987	26.0305	26.2347	26.3193	26.2039
170192	1.8218	0.8815	30.9230	31.7531	31.2268	31.3144
170193	***	*	24.4131	21.9349	*	23.1732
170194	1.3210	0.9510	28.2004	29.8055	35.7155	31.0241
170195	2.6049	0.9510	29.1787	31.0187	31.1398	30.5878
170196	2.4657	0.8815	29.9671	29.9241	30.4754	30.1281
170197	2.3696	0.8815	*	*	33.5828	33.5828
170198	1.9628	0.7987	*	*	21.2665	21.2665

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)
180064	1.3127	0.8169	21.9517	22.5090	22.7930	22.4374
180066	1.0981	0.8491	24.9542	27.2184	27.9386	26.6858
180067	2.0349	0.8731	29.6053	28.9896	29.8447	29.4895
180069	1.0562	0.8726	27.6785	29.9406	32.9954	30.0135
180070	1.3985	0.8080	21.3707	22.8450	24.2379	22.8579
180078	1.1477	0.8726	29.2136	27.4672	28.5407	28.3958
180079	1.1129	0.8134	24.9911	27.2710	26.6406	26.2936
180080	1.2983	0.7968	25.3013	27.2402	28.8878	27.1716
180087	1.3935	0.7968	22.1063	23.2617	24.6601	23.3427
180088	1.8784	0.8817	30.7954	31.8151	32.8802	31.8417
180092	1.2199	0.8731	25.2900	27.0330	26.1008	26.1589
180093	1.6163	0.8112	22.3330	23.5805	24.2286	23.4003
180095	0.9817	0.7968	21.2162	23.9869	25.2722	23.4669
180101	1.3075	0.8731	28.8772	29.6176	31.3655	30.0002
180102	1.5096	0.8401	27.3901	28.3445	28.2000	27.9841
180103	1.8987	0.8731	29.7648	31.7171	33.4864	31.6595
180104	1.5028	0.8401	27.1292	28.7669	29.7513	28.5720
180105	0.9798	0.7968	24.3663	22.9902	23.8754	23.7493
180106	0.8418	0.7968	21.2271	20.1899	21.6345	21.0320
180115	0.9093	0.7968	22.7095	24.9627	24.7207	24.1583
180116	1.3811	0.8401	26.8850	26.9052	28.8319	27.5303
180117	0.8909	0.7968	24.9571	25.9593	32.4295	27.4613
180124	1.4443	0.9245	27.1359	28.2511	30.0315	28.4139
180127	1.3104	0.9589	28.3635	29.8610	30.7302	29.6651
180128	0.9465	0.7968	23.7778	23.9098	25.5715	24.4166
180130	1.6650	0.8817	29.6751	31.2746	32.7358	31.2564
180132	1.3644	0.8604	29.0563	29.5884	29.0716	29.2342
180138	1.2014	0.8817	29.2603	30.7144	32.5383	30.8681
180139	1.0292	0.7968	26.2450	28.3450	28.6282	27.6824
180141	1.9520	0.8817	28.7329	29.5347	30.5211	29.6173
180143	1.7482	0.8731	28.0780	29.0323	30.9783	29.3852
180149	1.0602	0.7968	16.4918	16.3670	21.0272	17.8129
180150	***	*	*	27.9388	*	27.9388
180151	***	*	*	*	30.4651	30.4651
190001	1.2286	0.7914	22.5331	25.3862	29.4329	25.9377
190002	1.6804	0.8522	25.9387	27.1770	27.9720	27.0313

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)
170199	***	0.9510	*	*	*	*
180001	1.3332	0.9589	29.9674	29.7832	30.9806	30.2378
180002	1.0159	0.8022	27.3344	28.4044	31.5409	29.0284
180004	1.1704	0.7968	22.0626	25.7454	24.9498	24.2658
180005	1.1872	0.7968	27.4317	27.9687	27.9411	27.7817
180007	***	*	26.9440	29.3465	27.4649	27.8537
180009	1.7787	0.8877	28.7048	28.9804	29.4278	29.0599
180010	2.0260	0.8731	28.2168	29.8818	30.7745	29.6370
180011	1.7841	0.8604	25.0372	26.6072	27.6618	26.5186
180012	1.5168	0.8817	27.2851	27.8386	29.2398	28.1367
180013	1.5078	0.9245	26.8108	28.6307	30.5666	28.7198
180016	1.3865	0.7968	26.9539	28.2975	29.3693	28.1730
180017	1.3206	0.8307	25.4174	26.0927	26.1025	25.8744
180018	1.4264	0.8604	24.9874	25.0082	26.1008	25.3841
180019	1.1841	0.7968	27.6801	27.5969	28.3741	27.8956
180020	1.0587	0.8022	26.8865	29.8100	32.2231	29.5384
180021	0.9701	0.7968	22.3768	24.2127	25.2035	23.9235
180024	1.2076	0.8817	26.9553	27.8181	29.6219	28.1383
180025	1.4648	0.8817	28.4172	30.2576	30.4264	29.7370
180027	1.1926	0.7968	23.3881	24.0032	25.5838	24.3430
180029	1.3851	0.8604	26.3907	29.1400	33.4378	29.5232
180035	1.5342	0.9589	34.0370	36.6577	38.6609	36.4390
180036	1.4322	0.8877	30.2643	31.9987	31.3607	31.1858
180037	***	*	33.1897	28.5734	*	30.8765
180038	1.6881	0.7968	28.2430	28.5219	29.7899	28.8742
180040	1.8998	0.8817	30.2471	28.9562	29.3344	29.4231
180043	1.0208	0.7968	24.0582	25.0444	25.3235	24.8633
180044	1.7655	0.8726	25.7990	27.7934	29.8280	27.8627
180045	1.4112	0.9589	29.9366	29.9395	30.5323	30.1368
180046	1.1858	0.8731	28.5568	30.0536	32.2864	30.3552
180048	1.3799	0.8817	24.6800	25.3490	26.6093	25.5763
180049	1.5640	0.8604	23.5756	25.8921	26.3413	25.2334
180050	1.0789	0.7968	26.7726	29.9911	31.6382	29.3786
180051	1.3473	0.7968	25.2369	26.2560	27.0249	26.1980
180053	0.9345	0.7968	23.0302	24.6694	23.9168	23.8807
180056	1.1784	0.8353	26.3973	26.6223	27.8797	26.9629

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)
190003	1.4192	0.8522	28.0899	30.5381	32.3903	30.3006
190004	1.5130	0.7971	24.6563	27.0776	27.9512	26.6288
190005	1.6165	0.8960	28.3308	32.9927	37.7173	33.1276
190006	1.3802	0.8522	25.4826	28.9179	29.0957	27.9373
190007	1.1745	0.7914	24.0538	24.6117	25.6533	24.7748
190008	1.7700	0.7971	27.2683	28.1194	28.2295	27.8864
190009	1.0153	0.8137	25.0269	24.8263	26.5858	25.4967
190011	1.0472	0.8163	21.9174	24.2068	26.6768	24.1689
190013	1.5009	0.8167	22.8380	25.2468	25.4483	24.5356
190014	1.1793	0.7914	24.5410	25.6064	40.7446	28.3687
190015	1.4420	0.8960	26.9591	29.5241	30.0769	28.8937
190017	1.4652	0.8522	25.5477	26.9640	25.4691	25.9791
190019	1.7524	0.8137	27.6057	28.6311	28.7399	28.3525
190020	1.3278	0.8691	24.2361	25.9262	28.0236	26.1629
190025	1.3326	0.7914	26.5949	26.6296	28.3514	27.1651
190026	1.7583	0.8137	25.3752	27.0875	28.8866	27.0936
190027	1.6967	0.8167	31.5047	29.4789	30.3980	30.3893
190034	1.1283	0.8070	22.9920	24.3969	26.3515	24.6267
190036	1.7818	0.8960	29.1818	27.7969	28.4704	28.4460
190037	0.7254	0.8167	28.0463	19.5982	18.7954	23.3668
190039	1.6259	0.8960	24.6848	29.0738	29.9626	27.9926
190040	1.4743	0.8960	28.2444	29.0914	29.9663	29.1328
190041	1.5169	0.8608	28.7702	29.3296	30.0910	29.3837
190044	1.2801	0.8129	22.2462	23.1701	24.3730	23.2860
190045	1.5746	0.8960	27.5873	29.2569	30.1200	29.0376
190046	1.6328	0.8960	25.1890	30.9760	30.5381	29.0301
190050	1.2653	0.7970	22.7962	23.6921	25.5227	24.0035
190053	1.2074	0.8021	20.6289	22.1404	23.5950	22.1792
190054	1.3179	0.7984	23.5137	26.5586	26.1113	25.4378
190060	1.4983	0.8167	19.8911	25.1496	27.7691	23.8810
190064	1.7058	0.8691	26.9960	28.6273	31.9791	29.2646
190065	1.7366	0.8691	22.9861	24.3651	27.9372	25.1102
190078	1.1497	0.8070	25.6943	26.0185	29.3232	27.0423
190079	1.1235	0.8960	25.3344	28.0268	29.1094	27.5258
190081	0.8388	0.7914	20.4111	21.2224	22.0115	21.2213
190086	1.3020	0.8163	22.2852	24.2040	26.9695	24.3179
190088	1.0754	0.8192	24.7450	29.5999	28.2021	27.5172
190090	0.9838	0.7914	25.8610	25.0681	27.3177	26.0682
190098	1.7167	0.8608	27.5058	27.8846	30.6494	28.7013
190099	1.0253	0.8022	25.7488	25.7136	28.4892	26.6696
190102	1.5099	0.8522	28.3090	28.6165	30.5570	29.1515
190106	1.1005	0.8137	24.2759	25.5188	28.9330	26.2121
190111	1.7590	0.8608	27.3192	28.8406	30.5645	28.9629
190114	1.0703	0.7914	20.3651	21.1463	21.6197	21.0595
190115	***	*	26.0285	25.7014	26.8100	26.0517
190116	1.0753	0.7988	24.2154	24.4439	24.8814	24.4870
190118	1.0876	0.8608	22.6572	22.3386	23.2811	22.7643
190122	1.0958	0.8691	22.8681	24.5686	31.3875	26.4857
190124	***	*	28.6713	*	*	28.6713
190125	1.6466	0.8163	26.6269	26.9761	28.8934	27.6105
190128	1.0737	0.8691	31.1819	32.2095	33.7938	32.4188
190131	1.0333	0.8691	28.5946	29.9837	*	29.2828
190133	0.9268	0.7996	23.9550	27.2643	30.2431	27.1208
190135	1.4976	0.8960	35.0547	43.3956	30.1749	34.5472
190140	0.9443	0.7944	23.6713	23.2346	24.0178	23.6396
190144	1.3143	0.8608	24.8866	25.8501	28.3000	26.4009
190145	0.9783	0.7965	21.3988	22.1298	23.2133	22.2658
190146	1.5988	0.8960	28.5984	29.8336	31.9220	30.1763
190151	0.8796	0.7914	20.6970	23.0032	23.1663	22.2531
190152	***	*	34.6508	34.6962	*	34.6751
190158	***	*	21.5594	*	*	21.5594
190160	1.5857	0.8163	25.8646	26.4460	30.4027	27.3639
190161	1.1145	0.8167	23.8073	24.8249	29.4496	26.1002
190164	1.1621	0.8137	27.7265	28.2630	29.1466	28.3883
190167	1.1858	0.8522	27.1981	29.3971	31.7072	29.4460
190175	1.4156	0.8960	30.5948	31.4039	32.4140	31.4531
190176	1.8915	0.8960	28.2192	32.2906	33.3630	31.0838
190177	1.8394	0.8960	29.7252	30.9158	33.1120	31.2402
190182	***	*	30.7058	*	*	30.7058
190183	1.3719	0.7971	23.3462	25.0395	27.5733	25.3154
190184	0.9910	0.7989	22.6144	22.5006	23.5623	22.8891
190185	***	*	36.7317	*	*	36.7317

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)
190190	0.9500	0.8163	27.5051	27.5875	28.9851	28.1190
190191	1.2692	0.8070	26.9656	28.1116	32.0215	28.8849
190196	0.8810	0.8522	27.7824	28.4697	30.6538	29.0020
190197	***	*	28.7044	29.4072	*	29.0218
190199	1.0401	0.8691	36.7128	29.8286	28.2969	31.3489
190201	1.1431	0.8167	26.8550	27.8244	29.9231	28.1866
190202	1.6103	0.8691	27.6463	27.8790	27.6410	27.7264
190204	1.5181	0.8960	32.9140	31.9034	33.9604	32.9159
190205	1.7463	0.8522	30.1687	31.6103	32.8350	31.5257
190206	***	*	32.0180	30.4228	*	31.2019
190208	0.8027	0.7914	24.9405	27.5238	30.0098	27.5704
190218	0.8614	0.8608	26.5251	26.9305	28.1218	27.1833
190236	1.4843	0.8608	26.9059	28.6472	30.3081	28.6599
190241	1.3729	0.7971	26.5320	27.5130	28.2906	27.5219
190242	1.3789	0.8691	26.9729	28.7307	28.9832	28.2902
190245	1.4118	0.8163	26.4166	26.6403	28.0146	26.9878
190246	2.1718	0.7989	31.7158	31.5003	31.9389	31.7302
190249	***	*	27.0975	28.3211	26.0200	26.9791
190250	2.2150	0.8960	32.8381	35.2699	34.8570	34.3594
190251	1.3719	0.8691	25.1594	27.3657	22.3809	24.6241
190253	***	*	22.2227	*	*	22.2227
190255	0.8263	0.8522	23.8035	27.8066	29.2014	26.9356
190256	1.0879	0.8960	25.9365	28.7148	28.7873	27.9107
190257	1.7222	0.8163	22.7512	24.2936	25.5140	24.1247
190258	1.8369	0.8608	25.1993	27.7948	22.8694	24.8266
190259	2.1986	0.8522	27.5518	28.9188	32.6256	29.7409
190260	***	*	33.6227	*	*	33.6227
190261	1.5307	0.8163	25.4757	28.7987	29.7518	28.0732
190263	2.3305	0.8522	29.7063	36.3082	35.0815	33.5942
190265	***	*	30.9260	*	*	30.9260
190266	2.9075	0.8691	24.3809	32.3423	32.8501	29.9612
190267	1.4667	0.8960	24.2794	27.6254	30.2413	27.6482
190268	1.5022	0.8522	29.1425	25.8619	27.3010	27.2578
190270	1.8564	0.8960	*	28.5382	29.0533	28.8192
190272	1.3915	0.8522	28.4558	28.4184	23.0666	27.0073
190273	1.8338	0.8691	*	22.7627	21.7796	22.2208

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)
190274	1.8427	0.8960	*	*	28.1093	28.1093
190275	***	*	*	*	29.8167	29.8167
190278	2.3634	0.8608	*	*	23.8924	23.8924
190297	1.1631	0.7914	*	*	*	*
200001	1.3741	0.9646	28.1145	28.9839	29.1644	28.7658
200002	1.2267	0.9467	33.2695	30.4965	27.7474	29.9678
200008	1.4018	0.9891	29.3538	32.3955	34.3694	32.0896
200009	1.9252	0.9891	35.0743	36.9995	36.6174	36.2306
200018	1.3541	0.8546	24.6790	25.4228	25.7040	25.2718
200019	1.4200	0.9891	28.3413	30.1233	30.4128	29.6117
200020	1.2880	1.0167	34.5762	36.9185	40.2138	37.3298
200021	1.2139	0.9891	28.7614	31.8322	32.8504	31.2403
200024	1.6897	0.9467	31.0799	31.6913	31.9691	31.6010
200025	1.0822	0.9891	29.3607	30.2866	27.5879	29.0483
200031	1.2922	0.8546	23.7553	25.5973	25.9002	25.1162
200032	1.0966	0.8913	27.2276	27.8426	29.5243	28.2299
200033	1.8148	0.9646	33.6293	34.8017	34.8309	34.4334
200034	1.5798	0.9467	28.0417	28.5612	29.9152	28.9053
200037	1.1561	0.8546	26.7815	27.9167	29.6904	28.2013
200039	1.3319	0.9467	28.8043	29.9958	31.1058	30.0128
200040	1.0262	0.9891	25.5519	29.6104	29.7500	28.2937
200041	1.2990	0.8546	27.5067	28.7604	34.7965	30.1905
200050	1.1681	0.9646	30.1473	32.0363	34.1261	32.1587
200052	1.0602	0.8546	25.6238	24.4545	27.8859	25.8948
200063	1.1945	0.8546	28.2203	29.6832	30.0468	29.3650
210001	1.5177	0.9553	31.2355	30.9218	34.1405	32.0924
210002	2.0643	1.0153	36.0252	36.8782	37.3937	36.7875
210003	1.5893	1.0528	28.2566	34.4117	33.3035	31.7991
210004	1.4458	1.0363	33.9037	32.4548	34.4052	33.6051
210005	1.4195	1.0363	32.4081	32.2224	35.9981	33.5783
210006	1.1291	1.0153	27.9859	31.8510	33.3332	31.1089
210007	1.7980	1.0153	31.4125	35.3019	40.3611	35.4036
210008	1.4858	1.0153	31.8535	33.0343	33.5982	32.8704
210009	1.8265	1.0153	31.8273	34.4385	37.6618	34.7002
210011	1.4747	1.0153	30.7547	29.7694	28.5954	29.6627
210012	1.7244	1.0153	32.5327	33.8099	34.9499	33.8046

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)
210013	1.3276	1.0153	32.1180	35.6347	37.0309	35.0320
210015	1.3298	1.0153	31.6903	34.7961	35.0627	33.9065
210016	1.8075	1.0363	35.3253	37.1478	38.1730	36.9043
210017	1.1984	0.9258	26.6208	27.9652	27.6526	27.4185
210018	1.2329	1.0363	31.5460	33.7284	36.4116	33.9771
210019	1.7439	0.9258	30.5485	30.8121	31.7920	31.0527
210022	1.5465	1.0363	36.1833	35.8394	37.6668	36.5857
210023	1.5697	1.0188	34.1664	35.8243	37.3114	35.8019
210024	1.7983	1.0153	34.5548	36.7920	36.8980	36.1076
210025	1.3682	0.9258	23.5175	28.3956	29.8018	27.1435
210027	1.4746	0.9258	25.2143	25.6339	27.5954	26.1517
210028	0.9952	0.9641	28.5214	31.7636	34.3085	31.6966
210029	1.3475	1.0153	32.9100	33.9139	34.5028	33.8206
210030	1.1460	0.9258	29.1790	33.8729	34.4289	32.5388
210032	1.2840	1.0723	29.2785	31.6516	32.1111	31.0418
210033	1.2494	1.0153	28.4350	33.0982	34.9195	32.1665
210034	1.3548	1.0153	33.0407	35.1533	36.2137	34.8425
210035	1.3316	1.0528	30.6692	28.7165	33.9966	31.1330
210037	1.2971	0.9258	28.8708	31.0096	32.7623	30.9373
210038	1.3568	1.0153	31.1563	32.7411	36.1364	33.3828
210039	1.1580	1.0528	35.1172	33.7557	36.9784	35.3249
210040	1.2899	1.0153	31.0882	30.5834	32.5320	31.4054
210043	1.3938	1.0188	29.2762	31.9196	36.6996	32.5820
210044	1.3943	1.0153	31.5463	31.9067	33.9631	32.5139
210045	0.9460	0.9258	19.6112	23.8454	23.8618	22.3572
210048	1.4049	1.0153	29.2464	30.6650	32.7070	30.9328
210049	1.3689	1.0153	28.5970	31.5740	32.8674	31.1046
210051	1.3877	1.0528	30.7954	33.0355	33.8667	32.6191
210054	1.3042	1.0528	28.6905	32.3079	31.6544	30.9434
210055	1.3146	1.0528	30.2010	36.7615	34.9333	33.7035
210056	1.4309	1.0153	33.2271	35.5593	36.1699	34.9787
210057	1.4422	1.0363	33.7287	34.3643	36.7340	34.9628
210058	1.3962	1.0153	32.0669	32.9569	31.3066	32.0816
210060	1.1535	1.0528	32.5141	34.1974	35.0148	33.9373
210061	1.3663	0.9446	26.6842	28.6561	29.3130	28.2506
220001	1.3129	1.1629	32.0843	34.3993	36.2481	34.3049

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)
220002	1.3674	1.1675	35.9765	37.9204	41.2312	38.3799
220008	1.3871	1.1629	35.8680	37.3794	38.4675	37.2417
220010	1.2534	1.1629	33.7392	36.1759	37.1990	35.7179
220011	1.1936	1.1675	39.1234	41.0183	43.4561	41.2497
220012	1.4849	1.2761	41.7080	43.0551	45.5604	43.4384
220015	1.2957	1.0342	35.2373	36.6427	36.3521	36.1076
220016	1.1444	1.0342	33.1424	34.9714	36.4209	34.8480
220017	1.3175	1.2263	34.6575	38.0626	37.6958	36.8206
220019	1.1234	1.1629	26.3018	28.0084	29.0903	27.8070
220020	1.2029	1.1629	32.1528	33.6332	35.4953	33.7683
220024	1.3423	1.0342	33.0415	33.8692	34.5364	33.8309
220025	0.9616	1.1225	27.6973	26.6082	29.5427	27.9050
220029	1.2117	1.1629	32.6792	34.8311	36.1909	34.5986
220030	1.0618	1.0342	29.3714	28.8797	29.5771	29.2761
220031	1.5941	1.2263	39.4214	43.7983	46.0382	43.1193
220033	1.2423	1.1629	34.7005	36.1938	40.1693	37.0684
220035	1.4532	1.1629	36.1799	37.2879	39.7333	37.7394
220036	1.5744	1.2263	37.7301	37.0998	37.8277	37.5480
220046	1.5340	1.0430	33.8604	36.3356	37.1992	35.8553
220049	1.2222	1.1675	35.1134	35.7550	37.2393	36.0604
220050	1.1147	1.0342	30.3176	32.4636	33.3123	32.0693
220051	1.4962	0.9623	32.8693	34.7850	33.7617	33.7760
220052	1.2183	1.2263	34.9151	34.9505	36.2772	35.3988
220058	0.9958	1.1629	30.0344	31.9532	34.4725	32.1048
220060	1.1949	1.2263	36.8668	39.1180	41.2967	39.2136
220062	0.7353	1.1629	27.4755	27.3983	28.6100	27.8425
220063	1.3010	1.1675	32.2442	34.6004	35.5746	34.2266
220065	1.2968	1.0342	32.3814	33.6328	34.7503	33.5661
220066	1.4186	1.0342	*	32.6289	35.0799	33.8440
220067	1.2573	1.2263	33.9836	35.7611	37.4666	35.7573
220070	1.1469	1.1675	35.6271	37.4036	39.9802	37.7564
220071	1.8988	1.2263	40.0313	44.2752	45.3944	43.2726
220073	1.2200	1.1629	37.4249	38.9942	39.6741	38.7029
220074[4]	1.3861	1.1629	33.2081	34.5331	36.8057	34.8853
220B74[4]	***	1.2263	33.2082	34.5530	36.8057	34.8269
220075	1.6785	1.2263	33.3578	33.9698	34.6994	34.0061

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)
220077	1.7243	1.0962	34.7345	36.4382	37.6438	36.3180
220080	1.2906	1.1629	33.1640	36.8086	36.4442	35.4634
220082	1.4119	1.1675	32.2124	33.0780	34.8068	33.3688
220083	1.1280	1.2263	35.2758	37.6415	40.5318	37.8763
220084	1.3987	1.1675	34.6275	36.1148	37.5344	36.1294
220086	1.8041	1.2263	36.2385	38.7853	41.1504	38.7890
220088	2.0559	1.2263	37.0840	37.3891	39.2250	37.9105
220090	1.2951	1.1629	35.8969	36.8628	39.5890	37.5152
220095	1.1067	1.1629	31.1644	34.1504	35.3647	33.5995
220098	1.1646	1.1675	31.1288	32.1864	33.5372	32.2791
220100	1.3340	1.2263	35.7309	36.5606	39.5302	37.3023
220101	1.4456	1.1675	37.7292	39.3939	41.7510	39.6889
220105	1.2292	1.1675	35.8179	36.6444	39.1008	37.2184
220108	1.2101	1.2263	35.7009	37.1981	38.4683	37.1635
220110	2.0616	1.2263	43.8444	45.3683	47.3183	45.5482
220111	1.2935	1.2263	35.6223	36.8788	39.2826	37.2996
220116	1.8798	1.2263	40.0982	44.6345	47.0503	43.8997
220119	1.1259	1.2263	33.7200	36.2751	39.3797	36.4828
220126	1.2307	1.2263	35.6278	40.5321	38.0691	38.0034
220135	1.4968	1.2761	39.0296	40.3011	42.8786	40.7429
220153	***	*	20.5063	17.4773	*	19.2506
220154	***	*	*	*	43.7305	43.7305
220162	1.7710	*	*	*	*	*
220163	1.6759	1.1629	39.4893	41.6485	42.2607	41.1877
220171	1.6535	1.1675	36.4567	39.7385	38.8231	38.4015
220174	1.2280	1.1629	32.9140	35.8880	34.8969	34.5701
220175	1.3204	1.1675	34.1572	36.6376	38.0769	36.2663
220176	1.5591	1.1629	31.4220	36.2759	38.1115	35.1345
220177	0.9796	0.9623	*	*	*	*
230002	1.4172	0.9818	33.9708	34.2904	35.4051	34.5473
230003	1.4546	0.9343	28.9886	28.5041	30.5779	29.4047
230004	1.7665	0.9800	33.4644	33.1555	34.2513	33.6263
230005	1.3107	0.9050	29.0634	30.5550	31.2999	30.3027
230013	1.3464	1.0062	28.6430	29.9019	31.7624	29.9521
230015	1.1276	0.8875	28.9601	29.8884	32.5101	30.4496
230017	1.7269	1.0261	36.8045	35.5276	37.9085	36.7645

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)
230019	1.6780	1.0062	35.1440	34.8302	36.2681	35.4337
230020	1.7393	0.9818	29.9492	30.4302	31.1875	30.5255
230021	1.6302	0.9930	29.5414	30.4315	31.6126	30.5468
230022	1.1397	1.0044	25.7846	29.5713	32.6718	29.2749
230024	1.7276	0.9818	34.5278	35.1416	35.9717	35.2053
230029	1.7576	1.0062	33.1482	35.5257	33.5076	34.0730
230030	1.3448	0.9056	25.1929	27.8555	29.6448	27.5694
230031	1.5302	0.9677	30.8870	30.9321	31.9398	31.2474
230034	1.3190	0.8561	29.1098	29.8711	29.1055	29.3782
230035	1.3229	0.9270	25.7099	27.0372	27.3050	26.6784
230036	1.4412	0.8846	31.0938	31.9872	32.2736	31.7889
230037	1.2616	0.9818	28.8547	31.4423	32.0438	30.7784
230038	1.7841	0.9343	30.1040	31.5536	32.5233	31.4297
230040	1.1548	0.8561	27.2850	27.6894	27.5658	27.5168
230041	1.6226	0.9433	30.3082	31.7229	32.9136	31.6771
230046	1.9829	1.0057	33.5304	34.3952	35.9730	34.6914
230047	1.6075	0.9738	32.0248	33.2300	33.7230	32.9924
230053	1.7703	0.9818	33.5440	34.1884	35.6457	34.4992
230054	1.8298	0.9203	28.1229	28.5274	28.7081	28.4467
230055	1.3352	0.8561	28.1881	28.2657	29.6891	28.7234
230058	1.2321	0.8561	27.9643	29.2185	29.8938	29.0449
230059	1.6857	0.9343	28.3602	30.3935	32.7804	30.4880
230060	1.2298	*	28.7760	30.7515	*	29.7837
230066	1.2837	0.9800	32.3582	32.8383	34.5355	33.2614
230069	1.2686	1.0062	31.9675	33.3136	33.1693	32.8328
230070	1.6133	0.9164	28.0366	32.2151	31.6858	30.6195
230071	1.2460	1.0062	28.8879	29.6172	29.7818	29.4308
230072	1.4884	0.9343	28.8024	29.3214	30.4682	29.5558
230075	1.5124	0.9776	32.1166	33.2981	33.0825	32.8447
230077	1.8634	1.0062	31.0123	32.2274	33.2526	32.1563
230078	1.1159	0.8561	27.0069	27.7143	28.9136	27.8705
230080	1.1863	0.8561	25.6204	25.9082	27.1876	26.2388
230081	1.3269	0.8561	27.8106	27.9649	28.8166	28.2014
230085	1.1525	1.0261	27.6474	28.1395	28.6579	28.1825
230089	1.4386	0.9818	32.2311	34.4092	*	33.3212
230092	1.4241	0.9419	30.5417	29.5262	32.3277	30.8017

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)
230093	1.1780	0.8649	27.0572	27.7275	27.1783	27.3247
230095	1.1846	0.8846	25.9210	25.9787	26.7266	26.2097
230096	1.1720	0.9930	29.7225	30.9326	35.3048	32.0055
230097	1.6800	0.9270	31.5174	32.2990	31.8095	31.8749
230099	1.2400	0.9818	29.0975	30.7388	31.3285	30.3928
230100	1.4065	0.8561	25.6594	25.9480	27.1000	26.2233
230101	1.1279	0.8561	28.8608	29.4146	30.2695	29.5247
230104[5]	1.7305	0.9818	34.0195	34.0176	35.8511	34.6130
230B04[5]	***	1.0062	34.0195	34.0176	35.8512	34.6072
230105	1.7055	0.9270	32.1124	33.0444	32.7671	32.6577
230106	1.1686	0.9343	30.0223	29.0344	31.2467	30.1001
230108	1.2433	0.8561	25.7477	25.4728	26.0180	25.7519
230110	1.3362	0.8561	27.0280	29.0921	30.1773	28.7808
230117	1.8114	1.0261	33.9176	33.6962	34.2829	33.9706
230118	1.2950	0.8561	24.8638	27.1359	28.4411	26.8180
230119	***	*	33.2050	33.6503	*	33.4472
230121	1.3766	1.0044	27.7512	28.9511	30.8589	29.1516
230130	1.7250	1.0062	32.5613	33.6704	34.9168	33.7263
230132	1.6023	1.1325	38.2454	39.2894	39.7108	39.0878
230133	1.3475	0.8561	25.8537	26.1806	25.7131	25.9196
230135	1.0031	0.9818	31.5194	32.6527	*	32.0720
230141	1.6878	1.1325	36.3124	36.2647	40.7603	37.7978
230142	1.4114	0.9818	29.9911	30.2157	31.2225	30.4783
230146	1.4359	0.9818	29.0218	29.3346	30.5033	29.6410
230151	1.4202	1.0062	28.6724	28.6413	30.4793	29.2677
230156	1.7070	1.0057	34.7865	35.1696	34.0506	34.6656
230165	1.6917	0.9818	32.2855	31.9887	33.4485	32.6016
230167	1.6598	1.0218	32.8092	35.8019	36.9039	35.1674
230174	1.4021	0.9343	31.2469	31.6387	31.5749	31.4906
230176	1.4667	0.9818	29.2688	29.5281	30.9143	29.9016
230180	1.2683	0.8561	24.6007	28.1401	29.3494	27.1900
230190	***	*	33.6724	30.7924	36.7528	33.6252
230193	1.4023	0.9677	28.4641	29.1474	31.5867	29.7550
230195	1.5647	0.9738	32.5549	33.4975	33.4307	33.2170
230197	1.7706	1.1325	34.8066	36.4129	39.0745	36.8008
230204	1.4815	0.9738	30.1982	31.5389	34.3440	31.9730
230207	1.4333	1.0062	26.8231	27.2054	27.4058	27.1454
230208	1.2571	0.9270	25.2481	25.8892	27.8781	26.3654
230212	1.0316	1.0057	33.4379	34.3917	34.3146	34.0480
230216	1.5184	0.9677	28.9586	30.7478	30.8464	30.1816
230217	1.5091	0.9776	33.0839	35.4957	36.8987	35.2393
230222	1.6616	0.8846	32.4404	30.6277	29.6497	30.8334
230223	***	*	31.8146	34.2971	*	33.0613
230227	1.5877	0.9738	34.2762	35.4364	37.2173	35.5875
230230	1.4717	1.0218	31.4953	31.2614	35.4101	32.7671
230236	1.5236	0.9343	31.9100	32.1973	33.9658	32.7424
230239	1.4068	0.8561	23.5461	26.8301	25.7399	25.3662
230241	1.2282	0.9677	30.0248	28.4771	28.1961	28.8288
230244	1.4335	0.9818	32.5586	33.0082	34.3805	33.3248
230254	1.5845	1.0062	31.6332	33.3035	35.0085	33.2965
230257	0.9982	0.9738	30.0674	32.6298	33.3610	32.2051
230259	1.4407	1.0057	27.9572	28.7672	29.1847	28.6438
230264	2.1717	0.9738	29.2202	35.0990	32.8633	32.3749
230269	1.4542	1.0062	34.2694	34.4514	35.2406	34.6820
230270	1.4328	0.9818	29.2408	29.0416	30.1173	29.4610
230273	1.5702	0.9818	32.5730	32.6874	34.8769	33.4091
230275	0.5916	0.9164	22.3740	*	22.6282	22.5207
230277	1.6115	1.0062	32.2545	33.8036	33.9278	33.3433
230279	0.6904	1.0062	26.8552	26.8567	29.1055	27.6609
230297	1.8559	0.9818	*	35.4246	38.9074	37.1652
230300	***	*	*	40.1731	*	40.1731
230301	1.2227	1.0062	*	*	29.1345	29.1345
230302	1.4906	1.0062	*	*	*	*
240001	1.5641	1.0971	37.2211	38.3979	41.1328	38.9326
240002	1.8190	1.0743	34.6368	36.8748	39.2725	37.0026
240004	1.8454	1.0971	33.4596	36.5476	38.0743	36.0972
240006	1.2478	1.0705	32.8229	29.6609	33.3906	31.7311
240010	2.0987	1.0705	35.9131	37.5473	37.9714	37.1811
240014	1.0711	1.0971	33.4492	35.0675	34.9124	34.4948
240018	1.3136	1.0022	30.5645	32.3271	33.2165	32.0509
240019	1.1884	1.0743	34.2547	36.7033	37.3628	36.1276
240020	1.1431	1.0971	34.5703	34.6135	36.6755	35.2966

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)
240022	1.0184	0.9100	28.5905	29.9313	31.1820	29.9060
240030	1.5777	0.9100	27.6596	29.4253	30.4771	29.1795
240036	1.5881	1.1595	37.2207	39.2407	40.6807	39.1252
240038	1.5960	1.0971	34.7357	35.8365	37.8624	36.2034
240040	1.0412	1.0743	30.0255	31.3287	34.0408	31.7755
240043	1.2674	0.9100	25.7424	27.1539	28.4021	27.1223
240044	1.0396	0.9832	28.5705	29.8375	29.2853	29.2424
240047	1.5709	1.0743	35.6763	36.7122	37.9518	36.8053
240050	1.2531	1.0971	33.7964	34.6160	36.3327	34.9313
240052	1.2601	0.9100	31.0934	33.1438	33.8412	32.7258
240053	1.6040	1.0971	34.4210	35.4738	36.3375	35.4338
240056	1.3478	1.0971	35.8603	36.1085	32.7026	34.7789
240057	1.9154	1.0971	34.8374	35.4436	38.0267	36.0612
240059	1.1327	1.0971	32.5958	33.5784	33.2462	33.1583
240061	1.8971	1.0705	34.6031	36.2545	37.5518	36.1371
240063	1.6747	1.0971	36.9822	38.3735	38.3830	37.9453
240064	1.2584	0.9327	29.9917	34.2284	35.6416	33.1955
240066	1.6077	1.0971	39.6609	38.4941	39.9611	39.3771
240069	1.2417	1.0971	31.1673	31.6325	35.5305	32.8384
240071	1.1899	1.0971	32.5460	33.1094	35.2526	33.6572
240075	1.2925	1.0996	30.3230	31.5984	32.9099	31.6226
240076	1.1549	1.0971	33.7950	35.4135	37.1687	35.5171
240078	1.7615	1.0971	36.2276	37.3608	39.4917	37.6998
240080	2.0360	1.0971	36.5390	37.7353	39.9422	38.0831
240084	1.1431	1.0743	29.0275	30.3789	32.3231	30.5801
240088	1.2605	1.0996	30.7240	31.4165	32.7493	31.5959
240093	1.5139	1.0971	30.4744	31.3517	32.3603	31.4345
240100	1.3557	0.9100	30.9481	32.5307	33.0787	32.1897
240101	1.1930	0.9246	28.5503	28.7121	29.5062	28.9258
240104	1.3000	1.0971	35.8839	36.0711	40.3990	37.5173
240106	1.6415	1.0971	33.9984	36.8942	39.4418	36.7941
240115	1.5182	1.0971	36.2788	37.5802	38.9340	37.6699
240117	1.2305	0.9714	29.0894	30.4437	29.6560	29.7220
240132	1.4186	1.0971	36.4252	37.0941	37.9029	37.1610
240141	1.1176	1.0971	34.2473	35.8696	37.1761	35.6956
240166	1.2510	0.9100	26.1732	27.3184	28.1733	27.2405
240187	1.2545	1.0971	30.9646	33.5186	33.4685	32.6486
240196	0.8864	1.0971	35.0345	35.4472	38.7926	36.4381
240206	0.8428	1.4448	*	*	*	*
240207	1.3525	1.0971	36.4569	37.7179	39.4041	37.8925
240210	1.3728	1.0971	36.5950	37.7064	38.2157	37.5310
240211	0.6922	1.0138	16.6158	16.1460	16.5147	16.4214
240213	1.4249	1.0971	37.4608	38.4222	39.6119	38.5541
250001	2.1543	0.8033	24.3404	26.7079	28.0665	26.4327
250002	0.9292	0.8112	25.0342	31.2353	32.6748	29.5257
250004	1.8180	0.8920	24.8086	29.1096	30.0735	27.9168
250006	1.1385	0.8920	27.0511	26.9193	29.5377	27.8400
250007	1.1775	0.8780	29.3479	32.6672	29.5895	30.4767
250009	1.4344	0.8337	24.9118	25.9247	27.4107	26.1286
250010	1.0254	0.7685	22.7988	23.8749	24.5642	23.7451
250012	0.9436	0.9244	26.4110	29.8873	27.8117	28.0007
250015	1.3891	0.7685	22.3685	22.7775	24.6804	23.2704
250017	0.9972	0.7685	25.7404	25.5007	22.3055	24.4782
250018	0.7464	0.7685	19.1108	19.5527	20.4523	19.7089
250019	1.6160	0.8780	27.7230	28.4743	30.6047	28.9587
250020	0.9777	0.7685	23.1521	26.9602	27.3298	25.8101
250023	0.8903	0.8276	19.5081	22.2932	18.1265	19.8823
250025	1.1249	0.7685	23.0555	26.0579	25.2941	24.7563
250027	0.9255	0.7685	32.5451	26.7593	26.0018	28.1377
250031	1.3465	0.8033	26.7507	28.6356	29.2918	28.1897
250034	1.6373	0.8920	27.9279	29.3365	30.4186	29.2676
250035	0.7907	0.7685	20.5251	24.0653	21.6773	22.1583
250036	0.9473	0.8141	22.5676	22.6781	24.7286	23.3922
250038	0.8901	0.8033	30.7960	27.1958	27.6960	28.2735
250040	1.6037	0.8276	26.2268	28.4423	29.0556	27.8913
250042	1.2263	0.8920	27.4610	25.8791	29.9900	27.8246
250043	1.0488	0.7685	21.1265	22.4618	22.6883	22.0984
250044	0.9899	0.7685	26.1732	26.9451	27.9165	27.0209
250048	1.5964	0.8033	27.6339	27.4186	27.6413	27.5657
250049	0.9434	0.7685	24.2227	24.2129	21.5795	23.2747
250050	1.2840	0.7685	22.4429	22.6843	23.7761	23.0058
250051	0.7692	0.7685	14.1662	15.6982	15.7350	15.2511

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)
250057	1.2695	0.7685	22.9683	22.5524	25.9705	23.8168
250058	1.2848	0.7685	19.6720	20.4748	22.1219	20.7688
250059	0.9412	0.7685	25.5982	24.8145	23.7953	24.7423
250060	0.8138	0.7685	27.0354	31.0689	32.3075	29.8001
250061	0.8353	0.7685	25.1495	23.3006	22.9598	23.7099
250067	1.1274	0.7685	23.8027	28.2894	27.2252	26.3782
250069	1.6226	0.8389	23.4495	25.8456	27.7140	25.6751
250072	1.7556	0.8033	27.5791	30.5382	33.4227	30.5408
250077	0.9612	0.7685	19.6333	19.3962	20.7187	19.9351
250078	1.7165	0.8276	23.9598	26.5481	27.5407	26.0241
250079	0.8236	0.8033	46.0349	32.3758	33.2525	37.9276
250081	1.4366	0.8389	24.8281	23.1385	23.4104	23.7352
250082	1.5383	0.8269	25.6218	27.8096	29.4855	27.6774
250084	1.1549	0.7685	19.5694	20.1192	21.2238	20.3020
250085	0.9389	0.7685	24.6757	24.5765	25.8754	25.0279
250093	1.2675	0.7685	26.4351	27.0937	28.9805	27.5327
250094	1.6566	0.8276	25.4232	26.1331	28.4517	26.7021
250095	1.1011	0.8033	25.9021	30.7505	25.2077	27.0624
250096	1.2779	0.8033	27.7291	27.5206	28.2387	27.8348
250097	1.5766	0.8545	22.7916	23.6607	24.1412	23.5507
250099	1.4358	0.8033	27.5757	25.0076	26.7838	26.4464
250100	1.4971	0.8389	27.5484	28.2019	29.4847	28.4274
250102	1.5878	0.8033	25.5327	27.8758	27.2163	26.8662
250104	1.4298	0.8389	25.4008	26.3140	25.7698	25.8262
250112	0.9397	0.7685	27.4162	29.6978	23.5265	26.6016
250117	1.0807	0.8276	24.5706	26.0965	24.8836	25.2035
250122	1.1551	0.7685	23.4908	27.3606	29.9723	27.0453
250123	1.3700	0.8780	29.8299	29.5520	32.4446	30.5956
250124	0.8592	0.8033	21.9420	22.4247	23.9227	22.8064
250125	***	*	32.7411	29.0819	31.9595	31.3846
250126	1.0391	0.9244	25.2581	26.8712	26.7775	26.3501
250127	0.8051	1.4448	*	*	*	*
250128	1.0195	0.8130	23.5918	24.7051	26.7085	25.1917
250134	0.9778	0.8033	22.0846	40.7995	30.5003	30.6917
250136	1.0796	0.8033	27.1479	27.8270	28.3867	27.8135
250138	1.3635	0.8033	27.3132	27.0688	27.2446	27.2053
250141	1.5961	0.9244	33.4413	32.1496	32.1748	32.5419
250149	0.8744	0.7685	17.0964	17.2423	20.1464	18.0896
250151	0.6315	0.7685	*	17.3962	25.0867	22.3992
250152	0.9097	0.8033	28.5526	29.8216	30.9014	29.7409
250161	***	*	*	26.0070	*	26.0070
250162	1.0038	0.8805	*	*	31.4795	31.4795
250163	***	0.7685	*	*	*	*
260001	1.7887	0.8413	31.1866	28.6690	30.0091	29.9042
260004	0.9453	0.8119	23.9584	24.1764	25.5478	24.5773
260005	1.6662	0.9014	31.1050	33.1020	35.2586	33.2196
260006	1.5176	0.8119	33.8253	34.3548	36.2241	34.8332
260009	1.1928	0.8562	26.6685	26.2248	26.1679	26.3494
260011	1.6596	0.8562	31.2612	31.4415	31.6997	31.4704
260015	1.1557	0.8119	25.0250	25.1585	26.2688	25.5024
260017	1.3354	0.8562	26.2621	27.4586	29.5713	27.7693
260020	1.7611	0.9014	30.9599	32.0889	31.9873	31.7058
260021	1.4447	0.9014	19.5810	19.3770	32.4258	21.7238
260022	1.4859	0.8469	25.9391	25.6866	26.7007	26.0934
260023	1.5492	0.9014	25.5899	26.7586	27.4170	26.6175
260024	1.1778	0.8119	20.7136	22.4347	22.9454	22.0388
260025	1.4225	0.8913	24.5042	24.4959	25.1776	24.7304
260027	1.8912	0.9510	31.0236	32.3066	33.7743	32.3710
260032	1.9415	0.9014	28.7183	29.8257	30.8401	29.7990
260034	0.9685	0.8119	28.7736	29.7821	29.4667	29.3421
260040	1.7603	0.8485	27.3680	28.5035	30.9688	28.9626
260047	1.4981	0.8119	27.2667	27.1986	27.8230	27.4374
260048	1.2788	0.9510	29.6969	30.1691	30.8621	30.2465
260050	1.0775	0.8119	27.8065	27.6085	33.8763	29.6604
260052	1.3299	0.9014	29.6998	31.5722	32.2050	31.2103
260057	1.0671	0.9510	23.8181	27.0128	27.1286	26.1286
260059	1.2757	0.8163	25.3025	26.9521	27.3400	26.5869
260061	1.1228	0.8119	23.6717	24.7824	27.0444	25.1426
260062	1.3726	0.9510	29.6156	30.7159	32.0944	30.8710
260064	1.4339	0.8157	21.4932	23.6002	25.8364	23.6082
260065	1.7126	0.8485	28.3411	29.9325	29.6387	29.3274
260068	1.7723	0.8227	28.1246	29.3972	29.5603	29.0338

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)
260070	0.8779	0.8119	25.2997	26.2370	25.8515	25.8204
260074	1.2943	0.8227	28.6216	28.4171	29.3341	28.7892
260077	1.7066	0.9014	28.7204	28.9940	29.4924	29.0790
260078	1.2849	0.8119	23.1785	24.7794	25.1235	24.3410
260080	1.0588	0.8119	18.6813	19.0041	19.1529	18.9624
260081	1.6605	0.9014	32.0799	34.8761	40.1160	35.5594
260085	1.6239	0.9510	29.6514	30.4727	31.6209	30.5658
260091	1.5674	0.9014	30.2636	32.9623	33.9578	32.4263
260094	1.6223	0.8485	25.1491	27.0127	27.6983	26.6438
260095	1.5411	0.9510	29.9090	30.9142	30.5567	30.4750
260096	1.6341	0.9510	32.9383	33.1804	34.9531	33.6994
260097	1.1617	0.8477	27.3129	28.2444	28.5347	28.0208
260102	1.0526	0.9510	30.7678	29.1467	30.1726	29.9864
260104	1.7078	0.9014	29.5891	32.0122	33.6870	31.7800
260105	1.8595	0.9014	32.4292	33.4278	35.1637	33.6270
260107	***	*	29.7775	38.3668	*	33.8526
260108	1.8751	0.9014	28.5654	30.1064	31.5463	30.0736
260110	1.6558	0.8858	28.0381	28.5364	30.1039	28.9072
260113	1.2656	0.8338	23.0826	23.6758	25.6506	24.1533
260115	1.2365	0.9014	25.5658	26.5268	27.1941	26.4339
260116	1.0191	0.8338	22.5536	25.1758	27.7441	24.8970
260119	1.3362	0.8401	31.5003	26.4382	26.5860	27.9890
260137	1.7978	0.8413	31.4091	28.3521	29.0034	29.4967
260138	2.0048	0.9510	31.7582	33.4156	34.9774	33.4151
260141	2.0499	0.8227	26.6684	28.3492	28.1069	27.7513
260142	1.2469	0.8119	22.8205	25.0940	24.1296	24.0428
260147	0.8251	0.8119	22.9689	22.8326	25.3162	23.5729
260159	***	*	24.3027	25.5039	26.0669	25.2754
260160	1.0383	0.8263	26.6715	27.9585	25.0237	26.6867
260162	1.4325	0.9014	30.5761	32.3673	33.0685	32.0286
260163	1.2350	0.8213	23.8644	25.0443	26.1053	25.0488
260166	***	*	29.5259	30.6020	*	30.0575
260175	1.0460	0.9510	25.7069	26.5767	28.1625	26.8046
260176	1.7475	0.9014	30.6205	32.4957	33.1453	32.1183
260177	1.3018	0.9510	29.0815	31.1662	33.9887	31.4134
260178	1.9849	0.8227	26.9902	28.9170	29.8584	28.6253
260179	1.5711	0.9014	29.6316	30.3276	30.8087	30.2720
260180	1.7531	0.9014	30.7336	31.4721	32.7960	31.6529
260183	1.6167	0.8858	31.4916	32.2621	31.9939	31.9251
260186	1.5186	0.8562	29.1874	30.8706	32.4459	30.8700
260190	1.3538	0.9510	30.9003	32.2069	34.1776	32.3827
260191	1.5869	0.9014	27.8648	28.7185	29.0206	28.5553
260193	1.3548	0.9510	29.5436	30.5190	31.7169	30.5592
260195	1.4152	0.8119	25.0294	25.6697	26.6806	25.8066
260198	***	*	27.9093	31.4660	*	29.5529
260200	1.4152	0.9014	30.5032	32.0910	35.5243	32.9276
260207	1.1898	0.8485	23.6392	22.8308	22.7858	23.0788
260209	1.0738	0.8562	26.4203	33.7185	32.9152	30.8362
260210	1.2999	0.9014	36.4055	33.5701	35.4683	35.1634
260211	1.3016	0.9510	37.1557	42.4297	36.1826	38.3827
260214	1.3113	0.9510	31.0175	31.7957	34.1165	32.2652
260216	1.3206	0.9510	*	32.4039	33.4354	32.9949
260217	***	*	*	12.2879	*	12.2879
260219	1.3400	0.9014	*	*	30.7090	30.7090
260220	***	*	*	*	28.4854	28.4854
260221	2.0760	0.8485	*	*	*	*
260222	3.1344	0.9510	*	*	*	*
260223	2.1186	1.0325	*	*	*	*
270002	1.1098	1.0000	28.3379	26.9419	28.2453	27.8193
270003	1.2908	1.0000	28.0543	28.5127	29.8608	28.8323
270004	1.7281	1.0000	28.5869	29.4694	31.2211	29.8111
270012	1.6404	1.0000	28.0672	27.9087	28.8492	28.2728
270014	2.0243	1.0000	28.2582	30.1101	30.2964	29.5707
270017	1.3880	1.0000	29.3542	29.4260	31.2206	30.0036
270023	1.6600	1.0000	28.1896	30.9908	31.4981	30.2113
270032	1.0183	1.0000	21.6360	21.5106	23.5690	22.2261
270049	1.8451	1.0000	29.8891	31.3941	31.2314	30.8496
270051	1.4506	1.0000	29.3941	29.1163	30.1042	29.5449
270057	1.4282	1.0000	28.3627	29.5317	31.6450	29.8909
270074	0.9307	1.4448	*	*	*	*
270086	1.4090	1.0000	21.9017	27.3995	29.1206	26.4682
270087	1.5197	1.0000	24.9197	24.2168	24.9932	24.6952

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)
280003	1.8427	0.9442	32.3780	33.7700	34.1967	33.4246
280009	1.8904	0.9442	28.1559	31.9280	33.6233	31.2492
280013	1.7682	0.9507	30.3120	31.9793	32.8461	31.7420
280020	1.6813	0.9442	29.4831	30.3731	32.3562	30.7302
280023	1.4338	0.9442	30.0717	31.9420	31.3859	31.1391
280030	1.8814	0.9507	31.8758	33.4544	34.0068	33.0862
280032	1.4305	0.8846	25.6549	25.8707	27.6063	26.3985
280040	1.6949	0.9507	30.7406	32.1005	32.7669	31.9079
280060	1.7924	0.9507	30.4625	32.0607	33.5228	32.0474
280061	1.4381	0.8846	28.9591	29.2231	30.8514	29.7085
280065	1.2973	0.9380	29.5470	30.1143	31.0593	30.2322
280077	1.3795	0.9442	29.9223	29.7362	31.3173	30.3224
280081	1.6286	0.9507	28.9696	31.0768	35.8357	31.9381
280105	1.2687	0.9507	30.0472	33.3196	33.1381	32.1825
280111	1.1463	0.8846	28.3541	29.0865	29.9665	29.1181
280119	0.8685	1.4448	*	*	*	*
280123	***	*	20.2741	20.6384	29.1439	22.7001
280125	1.5076	0.8924	24.7466	25.1212	30.7283	26.8377
280127	1.9295	0.9442	26.5659	28.4607	27.8155	27.6847
280128	2.7835	0.9442	27.1024	19.2781	30.1848	25.4877
280129	2.0282	0.9507	27.9511	30.4258	30.9548	29.8713
280130	1.4549	0.9507	29.9645	32.4243	33.1309	31.9734
280131	2.1542	0.9507	*	*	*	*
290001	1.7980	1.0387	33.3318	32.3610	34.3346	33.3423
290002	0.8656	1.0000	22.7362	25.4458	22.9957	23.6408
290003	1.8020	1.1751	34.6433	36.8494	40.5318	37.2929
290005	1.5573	1.1751	34.2373	34.2514	36.3928	34.9732
290006	1.1041	1.0387	33.3243	32.9232	35.2704	33.8397
290007	1.8733	1.1751	41.2395	44.0851	42.0089	42.4271
290008	1.2259	1.0000	33.2473	36.1620	38.0955	35.8457
290009	1.8183	1.0387	34.2103	38.6692	40.9646	37.9146
290012	1.3732	1.1751	38.3731	38.1494	39.8895	38.8309
290019	1.6158	1.0387	32.2817	34.3215	35.6845	34.1518
290020	0.9789	1.0000	27.2908	25.3592	28.1691	26.9884
290021	1.6573	1.1751	36.8728	39.5976	41.5585	39.3326
290022	1.7355	1.1751	38.8262	40.9896	41.3452	40.4263
290027	0.8303	1.0000	29.1123	25.1315	17.5174	22.5697
290032	1.4270	1.0387	36.9175	38.9632	37.5969	37.8092
290039	1.6578	1.1751	34.6359	37.5722	41.3009	37.8433
290041	1.4861	1.1751	38.4445	40.0602	42.8244	40.5602
290045	1.7861	1.1751	38.2560	38.5440	40.6036	39.1847
290046	1.5403	1.1751	38.3112	41.5550	42.1258	40.8018
290047	1.7100	1.1751	35.6381	38.6892	41.6480	38.6953
290049	1.4003	1.0387	33.4278	33.2014	34.9138	33.8533
290051	2.0280	1.0231	32.5277	37.2727	37.4762	35.6509
290053	1.7043	1.1751	*	*	41.7548	41.7548
290054	1.3973	1.1751	*	*	*	*
290055	1.5038	1.0231	*	*	*	*
300001	1.4814	1.1003	31.0122	31.4533	31.9198	31.4782
300003	2.0987	1.1003	37.7246	37.3007	40.3073	38.5845
300005	1.4367	1.1003	28.8402	29.4927	32.0348	30.1484
300011	1.3554	1.1003	33.0785	32.7459	35.8987	33.9458
300012	1.4793	1.1003	33.0569	34.8519	34.3061	34.0954
300014	1.2376	1.1003	30.7735	32.8211	33.7508	32.5346
300017	1.4332	1.1003	33.4164	35.2028	37.5404	35.3981
300018	1.3748	1.1003	31.5028	32.7008	33.9503	32.7451
300019	1.3351	1.1003	28.3114	30.5332	31.7345	30.2363
300020	1.4207	1.1003	32.4655	34.7678	36.3046	34.5825
300023	1.4607	1.1003	32.3202	34.2636	35.1262	33.9571
300029	1.8966	1.1003	32.0033	35.3112	36.0153	34.4454
300034	1.8501	1.1003	33.5537	33.7397	32.8408	33.3556
310001	1.8394	1.3122	41.4946	44.8619	50.6197	45.4370
310002	1.8317	1.2845	37.9484	39.7599	41.3140	39.7102
310003	1.3084	1.3122	40.1543	39.8679	42.8025	40.9650
310005	1.3923	1.1292	34.7657	34.4087	36.0805	35.0978
310006	1.4947	1.3122	30.4296	29.1025	36.9349	33.0375
310008	1.4134	1.3122	34.3268	36.2903	37.2661	35.9659
310009	1.4910	1.2845	35.4624	37.9098	37.8290	37.0567
310010	1.3390	1.1246	36.0823	34.1071	34.7136	34.9256
310011	1.3734	1.1246	37.4855	34.0850	38.0642	36.5086
310012	1.5578	1.3122	41.9630	41.3814	44.1909	42.5312
310013	***	*	32.9488	*	*	32.9488

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)
310014	1.9878	1.1246	35.0124	39.7527	42.5930	39.1428
310015	1.9757	1.2845	40.8229	39.5076	41.0830	40.4736
310016	1.3519	1.3122	41.0363	39.7563	42.6276	41.1057
310017	1.3342	1.2845	35.9806	34.8881	36.6774	35.8563
310018	***	*	32.6956	33.5069	33.6833	33.3020
310019	1.5578	1.3122	31.8930	34.6618	36.9073	34.4769
310020	***	*	38.4266	34.8440	33.1723	35.6438
310021	1.5817	1.1246	32.2064	33.2554	32.9713	32.8092
310022	1.3683	1.1246	32.8079	32.8154	34.9947	33.5907
310024	1.4947	1.1292	36.8666	34.7011	39.0809	36.9202
310025	1.4049	1.3122	32.1481	35.2564	40.8638	35.5453
310026	***	*	30.1321	31.9905	*	31.0489
310027	1.5531	1.1292	34.6471	34.1653	35.9734	34.9324
310028	1.2605	1.1292	34.8332	37.2987	38.5589	36.9468
310029	1.7816	1.1246	35.2084	36.5179	37.3175	36.3361
310031	2.6733	1.1246	39.5911	38.2643	39.1348	39.0021
310032	1.4461	1.1246	35.2402	35.8019	38.5311	36.5407
310034	1.4950	1.1246	36.8614	37.1191	38.7280	37.5633
310037	***	*	40.4642	44.3134	40.6931	41.8671
310038	1.8962	1.2845	39.8707	40.7395	41.0685	40.5727
310039	1.3494	1.2845	32.6425	33.4253	37.6912	34.5040
310040	1.2885	1.3122	41.2246	38.3232	42.0815	40.6004
310041	1.3677	1.1246	35.2009	34.4308	35.9862	35.2145
310044	1.4058	1.1246	33.5868	35.9981	36.7810	35.4371
310045	1.6751	1.3122	39.2097	40.3222	39.6432	39.7338
310047	1.3605	1.1246	37.7220	38.1213	38.6503	38.1611
310048	1.3744	1.1292	34.5256	33.9641	35.1051	34.5359
310050	1.3717	1.2845	37.9214	32.5213	36.1693	35.4048
310051	1.5361	1.1292	39.7671	37.9104	41.4288	39.7278
310052	1.4235	1.1246	36.5494	36.2042	36.6700	36.4762
310054	1.3353	1.2845	38.2432	37.2851	38.6039	38.0252
310057	1.4774	1.1246	34.2052	32.8649	33.3683	33.4401
310058	1.0417	1.3122	30.4436	32.1349	27.4965	30.0818
310060	1.4272	1.1246	27.9134	30.4626	30.8243	29.7152
310061	1.3306	1.1246	33.5586	33.6084	36.9633	34.7277
310063	***	*	38.1481	36.7131	40.5704	38.4240
310064	1.6138	1.1246	39.8091	39.9456	39.4478	39.7300
310069	1.2782	1.1246	35.1376	36.9367	38.6289	36.8937
310070	1.4374	1.2845	36.9999	36.8951	38.3959	37.4053
310073	1.8090	1.1246	36.9249	37.5317	38.0642	37.5036
310074	1.3788	1.3122	39.0729	35.9044	36.5016	37.2148
310075	1.3708	1.1246	33.5253	33.8979	36.9608	34.7981
310076	1.7422	1.2845	38.1671	39.0325	41.8459	39.6865
310081	1.4281	1.1246	31.7981	32.1241	34.1450	32.7027
310083	1.5302	1.2845	28.3406	28.2875	32.3764	29.6420
310084	1.2977	1.1246	34.9626	34.3130	35.9478	35.1053
310086	1.2760	1.1246	30.9467	31.4837	32.6603	31.7166
310088	1.1089	1.1246	31.2437	28.1703	30.2876	29.8984
310090	***	*	33.9174	36.2502	39.0442	36.2511
310091	1.2160	1.1246	35.2913	34.8679	36.2967	35.4724
310092	1.5401	1.1246	32.8431	34.8028	35.8684	34.4889
310093	***	*	32.3860	33.4460	31.7797	32.5368
310096	1.7501	1.2845	34.2014	36.3201	35.9687	35.5034
310105	***	*	32.0277	31.3423	38.1377	33.7373
310108	1.5387	1.2845	36.2848	38.3403	40.4195	38.3588
310110	1.3629	1.1246	35.6825	36.5227	34.9317	35.6881
310111	1.3887	1.1246	36.0748	38.3519	38.6440	37.7157
310112	1.3763	1.1246	34.5337	33.6207	34.5096	34.2199
310113	1.3519	1.1246	35.0245	38.0066	38.4661	37.2140
310115	1.4081	1.1246	32.1197	33.7061	34.3663	33.4217
310116	1.3231	1.3122	27.8677	35.3805	35.7474	32.7281
310118	1.3491	1.3122	32.8286	33.2234	33.7307	33.2593
310119	1.9233	1.2845	41.2997	46.1339	47.0978	44.7840
310120	1.0481	1.1292	35.1661	36.3365	37.6296	36.3748
310126	***	*	34.3189	*	*	34.3189
310127	***	*	*	40.1255	*	40.1255
320001	1.8271	0.9607	31.4193	33.6433	35.9709	33.8353
320002	1.5849	1.0734	34.1610	35.6036	37.4444	35.7726
320003	1.0965	1.0348	31.5792	31.4445	34.6756	32.5189
320004	1.3353	0.8963	28.2407	30.5543	31.0061	29.9067
320005	1.6317	0.9607	25.2168	26.4658	32.6752	27.9187
320006	1.2566	0.9607	28.5177	31.6888	35.2586	31.7627

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)
320009	1.7026	0.9607	31.3296	31.7240	33.1227	32.2250
320011	1.1092	0.9300	28.9951	30.6151	31.5873	30.3536
320013	1.2176	1.0348	31.2890	31.7159	31.8514	31.6255
320014	1.0148	0.9137	30.4803	29.8578	33.1419	31.2290
320016	1.1858	0.8963	26.6392	27.7121	27.8561	27.4326
320017	1.3865	0.9607	30.5787	30.9261	28.3782	29.6648
320018	1.5868	0.9137	28.3465	29.9038	32.8869	30.3574
320019	***	*	28.7067	31.8205	34.4911	30.4173
320021	1.5923	0.9607	29.6464	31.3577	32.8321	31.4477
320022	1.1128	0.8963	27.5152	28.7195	30.9188	28.9216
320030	0.9864	0.8963	25.5267	28.5145	29.5471	27.9609
320033	1.2665	1.0348	30.1846	32.8631	36.8236	33.1221
320037	1.1970	0.8963	27.8982	28.6968	28.7477	28.4526
320038	1.2537	0.8963	31.6526	33.2147	34.1606	33.0243
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	0.9228	27.4946	30.2997	31.3304	29.7836
320065	1.2319	0.9228	26.9130	27.9999	31.2772	28.6447
320067	0.8536	0.8963	25.4121	23.6677	26.3383	25.1458
320069	1.0613	0.8963	25.3151	26.5521	25.6503	25.8344
320070	0.9578	1.4448	*	*	*	*
320074	1.3254	0.9607	28.8088	29.8317	31.0520	30.0004
320079	***	*	31.5661	30.3600	*	30.9560
320083	2.2519	0.9607	32.9476	35.1125	33.6033	33.8462
320084	0.8797	0.8963	24.2902	25.9161	27.1314	25.8596
320085	1.7238	0.9137	28.4537	28.7114	30.1249	29.0958
320086	1.3497	0.8963	*	*	25.1158	25.1158
320087	1.6719	1.0734	*	*	42.5390	42.5390
320088	2.4348	0.9137	*	*	34.8303	34.8303
330002	1.7166	1.3122	34.7270	35.3553	37.0353	35.6951
330003	1.4425	0.8664	26.8363	27.7173	28.8494	27.8117
330004	1.3751	1.1037	30.3221	30.8305	31.6812	30.9512

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)
330005	1.6498	0.9580	33.2851	34.1763	35.4940	34.3360
330006	1.4087	1.3122	36.3305	38.6645	40.1656	38.4055
330008	1.1596	0.9580	26.2141	26.7882	28.4962	27.1548
330009	1.4682	1.3122	41.3797	42.4137	43.3334	42.4105
330010	1.1603	0.8361	20.5805	24.3033	*	22.4266
330011	1.2668	0.8888	26.8269	29.2672	30.3683	28.8444
330013	1.9518	0.8664	28.8039	29.2399	30.3410	29.4831
330014	1.4172	1.3122	46.3170	48.1054	48.9136	47.8271
330019	1.2184	1.3122	44.5669	46.8153	47.5698	46.3293
330023	1.5195	1.2845	37.5135	40.9595	42.7405	40.4791
330024	1.8856	1.3122	44.8070	46.2954	46.9012	46.0282
330025	1.1126	0.9580	24.2702	26.5550	27.7934	26.2081
330027	1.3420	1.2845	45.9571	49.0573	51.4842	48.8088
330028	1.5496	1.3122	38.0149	38.7770	44.2939	40.0562
330029	0.6085	0.9580	22.9332	23.7555	23.2830	23.3239
330030	1.2366	0.8665	25.5089	27.4344	29.0599	27.3444
330033	1.1516	0.8515	25.0215	26.7551	25.6363	25.7900
330036	1.2446	1.3122	30.4659	31.2701	33.0792	31.6267
330037	1.1595	0.8665	23.4915	24.4428	25.1744	24.3847
330041	1.3783	1.3122	37.1651	41.2299	45.3939	40.9855
330043	1.5215	1.2529	40.6094	42.4560	43.7325	42.2894
330044	1.3451	0.8694	28.2638	29.4872	31.0592	29.6078
330045	1.5074	1.2529	41.6565	44.7551	43.4754	43.2881
330046	1.5094	1.3122	52.2397	53.4532	55.0464	53.5965
330047	1.3009	0.8361	22.9948	27.4392	27.9751	26.2095
330049	1.6219	1.1384	34.9740	38.0110	39.1009	37.4078
330053	1.0453	0.8665	20.1303	21.4837	22.9118	21.4891
330055	1.6466	1.3122	44.2343	44.6905	45.0848	44.6842
330056	1.5790	1.3122	39.9662	40.5499	44.2553	41.5601
330057	1.8056	0.8664	30.1821	30.5006	31.3063	30.6705
330058	1.4159	0.8665	23.6296	25.3712	26.6393	25.2419
330059	1.6093	1.3122	45.3691	47.7115	48.5048	47.2306
330061	1.2404	1.3122	37.8649	38.8790	38.2223	38.3263
330064	1.4200	1.3122	41.5737	39.5994	39.7492	40.3474
330065	1.1305	0.9580	26.2288	28.6809	29.2462	28.0526
330066	***	*	27.2085	30.7011	31.6635	29.8069

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)
330067	1.4686	1.1384	30.7537	31.5572	33.4690	31.8959
330072	***	*	41.4605	40.5965	41.2562	41.1030
330073	1.1842	0.8665	25.1392	24.8055	27.0799	25.6757
330074	1.1789	0.8665	23.1016	24.6973	24.5244	24.0892
330075	1.1415	0.9952	23.7522	27.5360	29.7300	26.9508
330078	1.4769	0.9580	27.6682	30.8157	31.7955	30.0967
330079	1.4095	0.9282	27.9479	28.7349	30.3386	29.0011
330080	1.2278	1.3122	40.2067	47.4529	47.6620	45.2176
330084	1.0795	0.8282	27.3434	28.8661	32.3461	29.4876
330085	1.1543	0.8282	27.1707	27.7050	29.8140	28.2623
330086	1.4037	1.3122	40.9768	44.0362	43.8866	42.9603
330088	1.0424	1.2529	37.4716	41.8635	40.8072	40.0287
330090	1.5852	0.9141	27.7306	29.5626	31.1789	29.4912
330091	1.3864	0.9580	28.3034	30.9457	31.7474	30.3738
330094	1.2966	1.0107	28.6213	33.0706	34.7760	32.0879
330096	1.2839	0.8282	24.7895	24.8667	25.8270	25.1605
330100	1.0060	1.3122	39.3170	38.6625	42.2615	40.0965
330101	1.9953	1.3122	45.5412	49.6431	49.8722	48.3792
330102	1.5567	0.9580	27.2543	31.6270	31.8062	30.2061
330103	1.2588	0.8435	25.4919	26.1064	27.2366	26.3008
330104	1.4546	1.3122	36.5894	38.4254	39.2277	38.0443
330106	1.7129	1.2845	48.2903	47.2240	50.3143	48.5958
330107	1.2256	1.2529	38.0262	40.2541	42.4267	40.1982
330108	1.1028	0.8497	25.3023	25.5480	26.9785	25.9251
330111	0.9381	0.9580	23.2134	25.1572	26.0153	24.6739
330115	1.1378	0.9952	24.3898	27.0362	25.4483	25.6308
330119	1.8188	1.3122	41.2365	43.8894	45.5719	43.5269
330125	1.7757	0.8665	29.4817	30.4389	30.4073	30.1158
330126	1.3867	1.2845	37.7807	40.0542	42.0898	39.9962
330127	1.4712	1.3122	45.2554	51.8817	48.5211	48.5432
330128	1.2873	1.3122	43.3437	41.7875	46.9766	44.0317
330132	1.0753	0.8435	22.1452	23.4437	23.9279	23.1462
330133	***	*	39.9025	*	*	39.9025
330135	1.2525	1.1875	33.2314	35.3624	39.4483	36.0981
330136	1.6306	0.8664	25.4198	27.9525	28.3336	27.2660
330140	1.8705	0.9952	31.1333	32.7905	33.3783	32.4446

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)
330141	1.3455	1.2529	39.1733	41.4127	44.4141	41.7692
330144	0.9644	0.8338	24.9304	26.0623	28.4201	26.4216
330151	1.2456	0.8338	21.6339	23.4664	23.7267	22.9407
330152	1.4485	1.3122	39.5754	45.9310	54.7836	46.5551
330153	1.7004	0.8664	28.9944	31.7611	31.6824	30.8206
330154	1.5936	*	*	*	*	*
330157	1.3987	0.9952	29.7622	30.2745	31.5430	30.5471
330158	1.8465	1.3122	39.5946	41.6800	45.4282	42.4155
330159	1.3174	0.9952	33.8484	35.6944	36.1898	35.2785
330160	1.5849	1.3122	39.0970	42.1789	42.5949	41.2776
330162	1.2954	1.3122	38.7638	39.3460	40.5038	39.5611
330163	1.0935	0.9580	28.6252	26.3050	28.3947	27.7792
330164	1.5397	0.8665	29.8458	30.3023	31.3920	30.5325
330166	0.8986	0.8282	22.8506	23.2773	24.1261	23.4275
330167	1.6650	1.2845	39.2421	40.8753	40.4725	40.2055
330169	1.4020	1.3122	47.5404	49.7924	52.6428	49.9712
330175	1.1395	0.8555	26.7883	28.2085	29.0704	28.0487
330177	0.9519	0.8282	23.4299	26.0397	26.3522	25.2321
330180	1.3073	0.8664	26.8658	28.0975	28.8328	27.9615
330181	1.4442	1.2845	46.2181	47.2523	47.5947	47.0071
330182	2.3077	1.2845	42.7962	46.6346	47.1590	45.5357
330184	1.4461	1.3122	39.7242	41.3935	44.1179	41.7416
330185	1.3245	1.2529	39.6724	41.3543	42.6804	41.2513
330188	1.3394	0.9580	29.7318	30.7222	31.9323	30.8070
330189	0.9639	0.8664	25.8125	26.4233	27.1258	26.4657
330191	1.3966	0.8664	28.2949	29.3753	30.8188	29.5351
330193	1.5971	1.3122	40.0280	40.7257	41.4599	40.7594
330194	1.7160	1.3122	49.8886	49.9208	51.5069	50.4558
330195	1.6426	1.3122	43.3213	46.0878	46.8736	45.3758
330196	1.3574	1.3122	38.6949	42.8106	47.1206	42.9556
330197	1.1361	0.8282	26.5525	27.6437	28.8718	27.7152
330198	1.5031	1.2845	35.8715	37.9641	39.0827	37.6987
330199	1.1339	1.3122	39.4076	47.5059	46.3469	44.4296
330201	1.8227	1.3122	46.5114	51.2179	54.5763	50.6833
330202	1.3722	1.3122	38.7624	42.1074	46.7805	42.6285
330203	1.5060	0.9952	34.6525	33.9161	34.8928	34.4900

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)
330204	1.3905	1.3122	39.5324	44.8153	45.9027	43.4028
330205	1.3126	1.1875	35.3792	37.0171	39.7000	37.4533
330208	1.2411	1.3122	37.1735	38.7279	40.4862	38.7598
330211	1.2386	0.8282	24.9432	25.6929	25.1947	25.2853
330213	1.0549	0.8694	28.5370	30.0957	30.7706	29.8123
330214	1.9522	1.3122	43.3229	43.6872	45.3177	44.1763
330215	1.3738	0.8282	26.3978	28.0026	29.8618	28.0715
330218	1.1081	0.9952	28.4113	28.4369	28.6860	28.5165
330219	1.7911	0.9580	33.2147	38.3321	35.2744	35.5508
330221	1.6164	1.3122	42.5486	40.5201	40.5318	41.2434
330222	1.4126	0.8680	28.7858	30.5142	30.9205	30.1140
330223	0.9881	0.8282	27.1970	28.2638	29.7031	28.4068
330224	1.3051	1.1037	30.4784	32.4518	32.2372	31.7197
330225	1.2507	1.2845	32.9036	33.7052	32.9368	33.1782
330226	1.5413	0.8665	26.3685	25.7981	25.8035	25.9817
330229	1.2515	0.8282	23.9243	24.9977	25.8898	24.9404
330230	***	*	39.3863	39.5043	38.2877	39.1691
330231	1.1081	1.3122	48.9021	49.1983	55.0575	51.0151
330232	1.3400	0.8664	27.9615	28.7263	30.4395	29.0427
330233	1.7151	1.3122	40.8539	43.4873	45.0275	43.1267
330234	2.3642	1.3122	49.8804	55.2159	52.8367	52.7030
330235	1.1918	0.8282	30.8034	31.2218	32.2695	31.3927
330236	1.5342	1.3122	42.6205	45.0321	46.2181	44.6257
330238	1.1263	0.8665	23.3953	24.7086	25.0066	24.3856
330239	1.2644	0.8282	24.6391	24.7255	25.3731	24.9135
330240	1.2759	1.3122	41.6132	42.5871	43.4387	42.5650
330241	1.8864	0.9952	32.9275	34.7013	39.1048	35.5399
330242	***	*	38.7875	40.2224	38.6238	39.2416
330245	1.7049	0.8694	28.6698	29.3183	29.9945	29.3377
330246	1.4001	1.2529	35.9577	39.4705	37.8761	37.7512
330247	***	*	41.3465	39.8390	41.3940	40.8488
330249	1.3877	0.9952	26.9856	29.4003	31.3854	29.2564
330250	1.4215	1.0020	29.6186	32.1740	32.6608	31.4907
330259	1.4278	1.2845	39.0213	38.5914	37.9641	38.5465
330261	1.2872	1.3122	38.0216	37.9563	43.0378	39.7112
330263	0.9364	0.8282	24.2125	25.5991	27.1866	25.6729
330264	1.4015	1.1875	32.5050	35.1876	37.0700	34.9395
330265	1.2783	0.8665	22.7433	22.8141	23.4374	23.0076
330267	1.5186	1.3122	35.3907	38.1619	39.3069	37.7114
330268	0.9270	0.8282	23.9135	25.7738	27.2016	25.6547
330270	2.1604	1.3122	52.3154	55.7360	54.4868	54.2864
330273	1.4195	1.3122	39.7880	41.3568	43.8752	41.7324
330276	1.0974	0.8325	27.0445	28.5781	29.1287	28.2507
330277	1.3453	0.9141	30.8156	30.8543	30.9247	30.8656
330279	1.6990	0.9580	31.2393	33.7210	34.1529	33.0739
330285	1.9158	0.8665	31.8987	33.0830	34.8499	33.3304
330286	1.3682	1.2529	38.8556	40.3250	42.5744	40.6239
330290	1.6635	1.3122	39.8036	43.2989	45.9513	43.0508
330304	1.3128	1.3122	39.4632	39.7987	41.5317	40.2570
330306	1.5933	1.3122	39.0409	40.3216	43.4823	40.9695
330307	1.3162	0.9728	30.8121	33.6277	34.1319	32.8681
330314	***	*	22.6885	38.7241	*	24.3594
330316	1.3911	1.3122	37.9357	40.3783	41.6035	39.9731
330331	1.3669	1.2845	44.1734	44.3947	46.8997	45.1714
330332	1.3212	1.2845	38.6932	40.8557	43.4181	41.0498
330339	***	*	25.0057	26.8982	28.5048	26.7646
330340	1.2054	1.2529	38.4726	38.4180	42.2131	39.7060
330350	1.5307	1.3122	44.2389	47.8575	47.9976	46.7447
330353	1.4414	1.3122	46.0215	45.8432	49.5822	47.1701
330354	1.9646	*	*	*	*	*
330357	1.5294	1.3122	40.2132	45.4617	46.6380	43.1978
330372	1.3511	1.2845	37.0323	40.3348	43.3981	40.1426
330385	1.1384	1.3122	47.4017	51.5393	45.1427	48.1255
330386	1.3008	1.1292	32.9990	35.2560	36.5408	34.8005
330389	***	*	37.5908	39.3586	*	38.5126
330390	1.5026	1.3122	38.7652	35.4546	38.7687	37.4717
330393	1.7670	1.2529	38.9324	40.1511	41.2449	40.1571
330394	1.6358	0.8888	28.8074	30.5684	31.6219	30.3595
330395	1.3609	1.3122	50.1316	41.6484	45.4785	45.3874
330396	1.5484	1.3122	39.1956	41.6293	44.4651	41.8339
330397	1.4662	1.3122	41.1682	41.0651	42.7103	41.6102
330399	1.2742	1.3122	39.8023	41.7487	43.7522	41.7435

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)
330401	1.3844	1.2529	41.7839	47.0780	44.9136	44.5387
330403	0.8761	0.8665	28.7282	26.7473	23.7548	26.0010
330404	1.1578	1.3122	36.1069	36.8792	36.7374	36.5668
330405	1.1290	1.3122	35.2720	38.6588	39.7283	37.3578
330406	1.1795	0.8664	28.2733	28.0950	29.0793	28.3974
330407	***	*	*	*	22.8300	22.8300
340001	1.5740	0.9254	29.9718	30.6910	31.4240	30.7347
340002	1.8308	0.9011	30.7403	31.6973	32.7630	31.7627
340003	1.4893	0.8434	26.6831	28.0732	28.5468	27.8117
340004	1.5876	0.8930	27.9200	30.6110	31.1662	29.9143
340008	1.2878	0.8726	29.0661	30.7569	34.1019	31.2985
340010	1.4897	0.8434	29.5232	31.0327	32.4003	31.0261
340011	1.1201	0.8434	22.5152	23.6040	24.0580	23.4059
340012	1.2071	*	24.9271	*	*	24.9271
340013	1.2699	0.9087	26.9152	29.2509	27.6416	27.9345
340014	1.6864	0.8930	29.5350	29.4771	30.8340	29.9749
340015	1.4756	0.9087	30.0979	30.7573	28.8930	29.8827
340016	1.4468	0.8434	27.9651	27.2226	28.5532	27.9432
340017	1.4517	0.9011	28.4866	28.4785	30.0492	29.0190
340020	1.2373	0.8597	28.3461	30.5510	32.0719	30.2864
340021	1.5313	0.9087	31.3630	32.5625	31.4723	31.8008
340023	1.4538	0.9096	27.6921	29.5911	30.1071	29.1802
340024	1.3148	0.8577	26.9001	27.4770	28.5029	27.6231
340025	***	*	25.2846	25.8195	27.0360	26.0595
340027	1.2773	0.9147	26.6528	27.2788	27.9438	27.2936
340028	1.5908	0.9407	31.9872	31.7634	33.0033	32.2689
340030	2.1669	0.9615	31.2051	31.5786	33.0391	31.9606
340032	1.5602	0.9254	29.2080	29.3927	31.1485	29.9318
340035	1.0454	0.8434	26.0846	26.8821	28.5389	27.1700
340036	1.1481	0.9665	29.0646	29.9160	32.2456	30.4353
340037	1.3488	0.9087	30.5362	32.0484	32.2546	31.6353
340038	1.2142	0.8763	26.2600	26.9487	27.5597	26.9240
340039	1.3643	0.8930	29.5069	30.2952	30.5856	30.1233
340040	1.9443	0.9298	30.1280	31.3866	32.6194	31.4417
340041	1.5949	0.8608	27.1285	27.8408	26.9689	27.3106
340042	1.2562	0.8434	27.0597	27.0729	27.4623	27.2060
340047	1.8790	0.8930	28.7620	30.6701	31.8464	30.4232
340049	1.9406	0.9615	31.5555	35.4171	37.3125	34.8782
340050	1.3906	0.9193	29.2290	30.4447	30.6227	30.1175
340051	1.3116	0.8495	25.4981	25.4162	27.3169	26.0648
340053	1.6844	0.9254	30.8342	30.9274	32.3059	31.3829
340055	1.3835	0.8608	29.0116	29.5040	29.9558	29.5156
340060	1.1756	0.8952	26.8387	27.3403	27.6187	27.2828
340061	1.8918	0.9615	31.2910	33.4821	35.0098	33.3700
340064	1.3481	0.8434	25.0814	27.2184	23.8839	25.2958
340068	1.3615	0.8665	24.7409	27.3499	29.9945	27.4055
340069	1.8686	0.9665	32.2171	32.5361	34.5375	33.1283
340070	1.3306	0.9033	27.7679	29.0391	30.6771	29.1880
340071	1.1590	0.9665	29.7343	31.3756	33.3372	31.6494
340073	1.8342	0.9665	33.1054	33.2705	35.0521	33.8494
340075	1.4189	0.8608	26.8315	29.1504	29.1977	28.3913
340084	1.2918	0.9254	25.6885	27.4289	28.6138	27.2146
340085	1.3401	0.8952	29.1095	29.9176	30.6533	29.9093
340087	1.2638	0.8434	23.8360	25.0091	24.8598	24.5686
340090	1.4562	0.9665	28.3615	28.6805	30.2204	29.1048
340091	1.6471	0.8930	30.4371	31.2643	32.1033	31.2815
340096	1.2936	0.8952	26.5814	26.8103	28.8252	27.3925
340097	1.2417	0.8434	27.9810	29.8702	31.0968	29.7085
340098	1.6521	0.9254	31.3916	31.8472	32.6855	31.9915
340099	1.3129	0.8434	26.0077	28.1143	27.2308	27.0980
340104	***	*	19.9492	20.2901	22.6818	20.9665
340106	1.1483	0.8434	24.5154	24.4254	24.4640	24.4672
340107	1.1997	0.9078	27.3565	28.5859	31.3953	29.1897
340109	1.3875	0.8910	26.6479	28.6310	29.6116	28.2987
340113	2.0509	0.9254	32.3786	32.4983	33.7443	32.8906
340114	1.6329	0.9665	30.1207	32.3730	33.8982	32.1928
340115	1.6196	0.9443	28.0974	28.9265	30.1300	29.0554
340116	1.6601	0.8608	29.9447	30.8834	31.7073	30.8393
340119	1.5385	0.9254	27.2938	28.1090	27.5688	27.6650
340120	1.1905	0.8434	26.1465	26.6358	25.4857	26.0885
340121	1.2056	*	25.1577	25.7488	*	25.4596
340123	1.4033	0.8952	28.7150	29.9077	30.2525	29.6494

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)
340124	***	*	25.7294	25.2498	*	25.5286
340126	1.4018	0.9665	30.6902	31.7266	32.8363	31.7725
340127	1.3442	0.9443	28.8675	30.8152	29.2734	29.6590
340129	1.4724	0.9087	31.7863	27.7470	27.8582	28.9876
340130	1.3943	0.9254	29.5294	30.4887	31.5637	30.5974
340131	1.5012	0.9147	29.6571	32.1743	32.7141	31.5473
340132	1.2123	0.8434	25.3264	25.9153	27.9417	26.4192
340133	1.0352	0.8694	26.8850	27.2630	27.7476	27.3127
340137	***	*	27.0874	28.8723	*	27.9808
340138	0.7851	0.9665	*	*	*	*
340141	1.7657	0.9278	29.3372	30.8628	32.7705	31.0063
340142	1.3540	0.8434	28.2413	28.4951	28.8001	28.5170
340143	1.6608	0.8608	29.3861	30.7162	30.7341	30.3029
340144	1.3389	0.9087	27.6548	26.5581	28.8387	27.6514
340145	1.3578	0.9087	28.0647	28.4230	30.2734	28.9479
340147	1.4283	0.9665	29.6960	30.2620	31.9770	30.6471
340148	1.5162	0.8930	27.9136	28.6607	29.4099	28.6776
340151	1.2488	0.8518	24.5782	25.9633	27.4838	26.0141
340153	2.2501	0.9254	29.8278	30.9065	31.9383	30.9161
340155	1.5111	0.9615	31.7570	31.6719	33.3200	32.2603
340156	0.9566	1.4448	*	*	*	*
340158	1.2800	0.9278	29.4110	29.2570	30.5782	29.7960
340159	1.2531	0.9615	28.1706	27.8427	28.4462	28.1620
340160	1.3305	0.8434	24.2016	24.9127	26.6299	25.2911
340166	1.4619	0.9254	29.9122	31.0779	32.0895	31.0468
340168	0.6198	0.9278	*	*	*	*
340171	1.2836	0.9254	31.1954	31.7831	32.9664	32.0428
340173	1.3664	0.9665	30.9843	30.9025	33.6245	31.9176
340183	1.4456	0.9254	30.1261	31.4691	33.8694	32.0521
340184	1.2205	0.9011	*	*	*	*
350002	1.9786	1.0000	23.6051	25.2966	25.6127	24.8324
350003	1.3396	*	24.5812	27.3546	*	25.9392
350006	1.5896	1.0000	23.4343	26.6508	24.4993	24.8200
350009	1.1530	*	23.9795	*	*	23.9795
350011	1.9178	1.0000	26.0201	27.3884	28.7922	27.4508
350015	1.7512	1.0000	22.9120	27.6960	27.5641	26.0655
350017	***	*	24.0968	*	*	24.0968
350019	1.7575	1.0000	24.9890	27.0960	28.0464	26.7617
350030	***	*	23.1023	*	*	23.1023
350063	0.9324	1.4448	*	*	*	*
350064	0.7461	1.4448	*	*	*	*
350070	1.7884	1.0000	26.2871	28.1430	27.2712	27.2387
360001	1.6025	0.9589	30.1038	31.8522	32.7806	31.5948
360002	1.4501	0.8650	25.2209	26.7549	28.6654	26.8766
360003	1.8677	0.9589	31.8976	31.9294	33.1644	32.3372
360006	1.9087	1.0127	31.8814	35.3579	37.9906	35.0506
360008	1.5052	0.8726	28.0202	28.5988	29.5431	28.7448
360009	1.6126	0.9222	28.2423	30.2452	30.8963	29.8065
360010	1.3386	0.8817	26.6040	27.3194	29.0960	27.6688
360011	1.4401	0.9988	29.9882	31.3142	31.2768	30.8735
360012	1.4610	1.0127	31.9837	32.9127	33.7084	32.8720
360013	1.1783	0.9017	30.2406	30.9331	32.0155	31.0828
360014	1.2374	0.9988	28.1811	28.9635	31.9658	29.7231
360016	1.5885	0.9589	30.2190	30.5892	31.9625	30.9278
360017	1.8785	1.0127	32.6006	34.8774	37.9229	35.0835
360019	1.3519	0.9051	28.8568	29.3536	29.8978	29.3771
360020	1.5714	0.9051	27.8079	29.5312	30.6866	29.3396
360025	1.4669	0.9340	28.4761	29.5329	30.0976	29.3789
360026	1.6064	0.9138	27.5757	27.3618	26.3357	27.0561
360027	1.5697	0.9051	29.9449	30.8898	32.5249	31.0962
360029	1.1553	0.9340	28.0191	29.0633	29.4148	28.8384
360032	1.3121	0.8558	27.2636	27.4896	29.0813	27.9432
360035	1.7082	1.0127	32.0858	32.5622	33.7704	32.7934
360036	1.2891	0.8884	29.9410	31.5027	32.2527	31.2390
360037	1.6216	0.9051	30.6552	31.5221	32.0723	31.4180
360038	1.7378	0.9589	31.3776	32.3095	34.0919	32.4969
360039	1.5460	0.8558	25.8216	27.3636	28.7255	27.2671
360040	1.2153	0.9003	26.7450	28.4404	29.8157	28.4184
360041	1.3782	0.9051	28.4439	29.3331	29.9787	29.2230
360044	1.2307	0.8685	24.7698	25.7011	25.6569	25.3777
360046	1.3090	0.9589	28.2972	28.5624	28.9044	28.5932
360048	1.8571	0.9340	30.0390	33.3273	39.7399	34.2473

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)
360051	1.7630	0.9138	29.4434	30.5937	31.1390	30.4096
360052	1.6740	0.9138	28.4731	29.8072	31.5068	29.8825
360054	1.5310	0.8726	23.6606	26.8828	27.5159	25.9613
360055	1.4571	0.9051	31.4794	31.2738	32.8912	31.8728
360056	1.5298	0.9589	31.3936	31.8378	33.3655	32.2218
360058	1.1411	0.8558	25.9295	27.7073	27.9493	27.1867
360059	1.7410	0.9051	30.6294	31.3956	32.6500	31.5846
360062	***	*	32.9025	35.2065	*	34.0497
360064	1.6958	0.8597	28.6101	28.5325	29.6967	28.9321
360065	1.2957	0.9340	31.5066	31.6781	32.9281	32.0480
360066	1.4780	0.9222	30.9652	32.1991	33.3893	32.2012
360068	1.9074	0.9340	28.6335	30.0212	30.0122	29.5516
360070	1.7211	0.8587	28.8739	30.0192	30.7743	29.8907
360071	1.1589	0.8629	25.7956	26.6139	29.0667	27.1676
360072	1.4371	1.0127	29.1514	29.8851	29.9269	29.6473
360074	1.4181	0.9340	28.0283	30.1333	30.4775	29.5352
360075	1.3041	0.9051	28.3930	29.8181	31.5280	29.9843
360076	1.6207	0.9589	29.5342	28.8462	39.7178	32.3946
360077	1.6129	0.9051	28.3022	26.2961	29.4356	28.0005
360078	1.3461	0.9051	27.3652	28.2973	29.8134	28.5286
360079	1.9369	0.9138	31.3132	32.0935	34.0308	32.4640
360080	1.2318	0.8558	21.8806	22.9825	23.4864	22.7862
360081	1.3978	0.9340	31.4293	33.2532	33.2048	32.6341
360082	1.3923	0.9051	30.5837	29.7447	31.0679	30.4753
360084	1.6721	0.8587	29.2489	29.2527	30.7638	29.7697
360085	1.9801	1.0127	33.1295	35.9664	36.9930	35.5207
360086	1.6162	0.9138	29.1579	31.9690	31.4870	30.8305
360087	1.5016	0.9051	28.6336	30.0084	31.6811	30.0610
360089	1.1498	0.8558	28.0779	28.5192	31.2533	29.2557
360090	1.4048	0.9340	29.2662	30.3175	30.9496	30.1588
360091	1.3254	0.9051	28.2009	29.6324	30.4237	29.4189
360092	1.3143	1.0127	28.0813	28.3576	30.1474	28.8454
360095	1.5618	0.9017	30.2138	30.0996	29.4329	29.8840
360096	1.1693	0.8569	27.9514	29.8687	30.9591	29.5843
360098	1.4382	0.9051	26.5839	27.6752	29.8094	28.0146
360100	***	*	25.8143	25.9628	25.6730	25.8198

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)
360101	1.4306	0.9051	30.6650	29.4661	30.1706	30.0954
360107	1.0926	0.8721	26.8180	29.9869	30.3798	29.1290
360109	1.1223	0.9988	30.4643	30.7873	32.3030	31.1771
360112	1.8127	0.9618	32.4403	34.6063	34.7054	33.9229
360113	1.3049	0.9589	30.3914	33.3293	33.4343	32.4613
360115	1.4149	0.9051	27.9711	29.0971	30.1601	29.1053
360116	1.2562	0.9589	26.8632	29.3122	29.7860	28.5964
360118	1.5008	0.8884	29.9823	30.1189	30.7809	30.3006
360121	1.3059	0.9340	31.6766	22.1967	32.9072	28.0628
360123	1.5042	0.9051	28.5435	30.0862	31.5113	30.0225
360125	1.2614	0.8558	27.1776	28.8237	28.0350	28.0061
360130	1.3605	0.9051	28.1811	28.5433	29.7361	28.7968
360131	1.4918	0.8587	27.3426	28.3618	28.7671	28.1650
360132	1.4508	0.9589	29.8411	29.5751	31.5596	30.3066
360133	1.7092	0.9589	33.1812	33.9534	34.8112	33.9924
360134	1.7893	0.9589	29.9198	31.9438	32.3469	31.4230
360137	1.8571	0.9051	30.3116	32.2727	33.2352	32.0133
360141	1.7533	0.8597	31.9397	32.0733	32.7749	32.2464
360143	1.4331	0.9051	28.0693	27.0053	29.2144	28.0938
360144	1.4492	0.9051	29.6547	29.5081	31.0392	30.0715
360145	1.5767	0.9051	29.3271	29.8688	30.7618	29.9934
360147	1.4745	0.8558	29.2371	28.0794	29.5791	28.9706
360148	1.2665	0.8558	25.7460	28.4538	29.4791	27.8738
360150	1.4450	0.9051	27.8840	27.8860	28.7351	28.1713
360151	1.3858	0.8587	26.9672	28.3917	29.2453	28.3547
360152	1.6437	1.0127	33.1017	35.3636	38.6173	35.6283
360153	1.0408	0.8558	21.8416	22.3028	22.2970	22.1445
360155	1.5129	0.9051	29.1711	30.0263	31.6330	30.2216
360156	1.2161	0.8721	26.2268	27.4185	28.7708	27.4922
360159	1.5048	0.9988	29.0187	29.1683	31.7154	29.9862
360161	1.4352	0.8608	27.7423	29.4713	29.7938	29.0163
360163	1.8520	0.9589	31.2087	31.1214	35.9273	32.7659
360170	1.3566	1.0127	30.0688	30.9891	30.4727	30.5164
360172	1.4106	0.9051	30.2330	31.2620	33.1911	31.5013
360174	1.4016	0.9138	28.3769	29.2419	29.6532	29.0983
360175	1.3096	0.9988	29.7499	31.8340	31.6997	31.1026

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)
360179	1.6158	0.9589	31.3540	30.6820	31.6893	31.2523
360180	2.5220	0.9051	32.0225	30.3025	32.9679	31.8008
360185	1.4175	0.8569	26.4210	27.4008	27.6493	27.1524
360187	***	*	27.3745	28.2630	31.4161	28.8670
360189	1.1225	1.0127	28.3738	28.8931	29.4683	28.9355
360192	1.4530	0.9051	29.1999	31.7957	32.2058	31.1247
360195	1.1421	0.9051	27.2630	28.4907	29.0945	28.2989
360197	1.3514	0.8558	28.5267	30.3316	31.0092	29.9907
360203	1.1956	0.8558	27.7569	28.7975	33.3229	29.9493
360210	1.4152	1.0127	31.8182	35.1678	37.5738	34.9681
360211	1.6242	0.8558	27.5081	26.9504	26.8651	27.1109
360212	1.4042	0.9051	28.5882	28.8865	31.1927	29.5436
360218	1.3838	1.0127	31.1641	31.4458	31.3279	31.3159
360230	1.5862	0.9051	30.5995	29.9181	31.1291	30.5468
360234	1.4362	0.9589	30.7926	29.5412	33.3635	31.1892
360236	1.4186	0.9589	29.9367	31.7585	32.1544	31.3126
360239	1.4331	0.9138	31.7938	32.3401	33.2672	32.5110
360241	***	*	25.8137	28.0304	29.5276	27.8945
360242	1.9199	*	*	*	*	*
360245	0.8463	0.9051	20.4589	20.8560	21.7611	21.1038
360247	0.6198	1.0127	*	*	20.0017	20.0017
360253	***	*	34.6887	33.3121	37.3858	35.0691
360259	1.3694	0.9340	28.0886	29.3681	31.0636	29.4813
360261	1.2686	0.8877	26.6262	28.2317	32.7858	29.2194
360262	1.3275	0.9340	31.5637	33.1908	34.1066	32.9406
360263	1.9512	0.9222	28.1671	25.5127	26.8589	26.7651
360266	2.2686	1.0127	29.8385	31.3706	33.4527	31.8472
360269	1.9619	0.9589	25.5191	26.3965	34.8420	29.0803
360270	1.1560	0.8558	28.8677	30.0580	32.1004	30.6365
360271	1.4738	0.9589	28.4353	30.8070	32.9685	30.7680
360272	***	*	38.1014	*	*	38.1014
360273	***	*	37.6645	*	*	37.6645
360274	1.6329	0.9138	*	*	41.5852	41.5852
360275	***	*	*	*	35.3381	35.3381
360276	1.3571	0.8597	*	*	30.8562	30.8562
360347	1.2052	1.0127	*	*	*	*

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	1.0127	*	*	*	*
360349	1.4026	0.9340	*	*	*	*
360350	1.8062	0.9589	*	*	*	*
360351	1.9867	0.8817	*	*	*	*
360352	1.0842	0.8597	*	*	*	*
360354	1.4011	0.9589	*	*	*	*
360355	1.5439	0.9051	*	*	*	*
360356	***	0.8721	*	*	*	*
370001	1.6993	0.8865	28.4907	27.2881	29.2874	28.3832
370002	1.2418	0.8021	26.2486	26.5804	28.5143	27.1323
370004	1.1751	0.8413	28.2804	27.2378	29.9201	28.4533
370006	1.2115	0.8760	25.2307	27.5299	28.6376	27.1056
370007	0.9619	0.8021	21.1260	25.7680	29.5816	25.5569
370008	1.4129	0.8857	27.9944	29.1467	29.2426	28.8401
370011	0.9562	0.8857	23.1761	24.5886	26.7272	24.8287
370013	1.4968	0.8857	28.3502	29.7899	32.8009	30.3601
370014	1.2150	0.8405	28.8962	29.3407	29.0672	29.1079
370015	0.9979	0.8760	27.8061	27.6086	27.8989	27.7715
370016	1.5857	0.8857	30.4672	29.6737	30.9791	30.3785
370018	1.5379	0.8760	31.2335	29.3285	29.9319	30.1144
370019	1.1741	0.8021	26.7613	30.4599	30.9034	29.3778
370020	1.5729	0.8857	24.7520	24.7484	26.5753	25.3609
370022	1.3858	0.8266	26.4836	24.4735	26.1483	25.6654
370023	1.3323	0.8092	24.9580	27.4272	27.8985	26.8570
370025	1.3829	0.8760	24.8336	27.0211	27.6924	26.4519
370026	1.4507	0.8857	26.0203	26.8057	28.1123	26.9930
370028	2.0270	0.8857	29.9849	31.9029	33.9488	31.9980
370029	1.1511	0.8021	30.0134	30.3712	30.9983	30.4592
370030	0.9910	0.8760	26.0831	26.5853	27.9524	26.8671
370032	1.4856	0.8857	28.0739	30.2497	29.6458	29.2891
370034	1.2867	0.8021	23.2192	23.9679	29.5326	25.5430
370036	1.0370	0.8021	21.1544	22.1686	21.3777	21.5605
370037	1.8563	0.8857	26.8992	28.9215	30.8687	28.8548
370039	1.1530	0.8865	25.3422	26.7579	27.7275	26.6241
370040	0.9917	0.8021	19.7644	21.6739	23.4305	21.6815
370041	0.8609	0.8865	29.5074	26.4346	25.4845	27.1145

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)
370047	1.4945	0.8857	27.8937	29.6739	32.3122	30.0341
370048	0.9653	0.8021	23.4848	24.2668	24.1310	23.9588
370049	1.4371	0.8857	24.2099	22.8526	28.2755	25.0591
370051	1.0771	0.8021	21.8716	22.8411	25.2407	23.3365
370054	1.2593	0.8021	23.4644	25.4821	31.2749	26.7347
370056	1.7795	0.8574	27.6178	26.9562	31.0178	28.6001
370057	0.9892	0.8865	23.1814	21.0790	22.8984	22.3254
370060	***	*	25.5571	29.0333	*	27.1132
370065	1.0374	0.8123	24.0062	23.7889	27.6137	25.2675
370072	0.7840	0.8021	22.8598	17.3061	22.6073	20.6797
370078	1.6690	0.8865	30.4837	28.7496	30.0368	29.7747
370080	0.9537	0.8021	23.7231	22.4258	20.5616	22.2157
370083	0.8441	0.8021	21.9162	21.3677	19.0700	20.7310
370084	1.0783	0.8021	17.4202	17.7119	16.9000	17.3309
370089	1.5651	0.8021	22.0607	23.8318	25.9129	24.0543
370091	1.7197	0.8865	28.0487	28.3945	29.9770	28.8346
370093	1.9314	0.8857	26.7272	29.0161	30.3371	28.6773
370094	1.4661	0.8857	28.3512	29.5931	29.7366	29.2576
370097	1.3617	0.8574	28.0911	28.1234	28.0444	28.0887
370099	1.0863	0.8857	30.5437	28.8908	29.8161	29.7109
370100	0.8879	0.8021	20.6298	18.2493	20.4975	19.7868
370103	1.0503	0.8021	22.2675	23.4746	23.9532	23.2339
370105	2.1142	0.8857	30.5438	30.9068	36.1150	32.0639
370106	1.5245	0.8857	29.6797	31.4433	32.4720	31.2183
370112	1.0149	0.8021	19.0130	20.2239	20.4676	19.9439
370113	1.1529	0.8458	30.0061	28.3511	28.2867	28.8876
370114	1.7327	0.8865	27.1348	32.9928	34.7573	31.4498
370138	1.0298	0.8021	23.6348	24.7631	28.4264	25.7185
370139	0.9194	0.8021	21.0759	19.3691	22.7638	21.0186
370148	1.5057	0.8857	29.3447	30.8781	32.6348	30.9676
370149	1.3740	0.8857	23.0764	25.0025	27.3443	25.0923
370153	1.0947	0.8021	25.9238	30.0891	28.8392	28.2730
370156	1.0078	0.8117	22.7140	22.3940	23.9489	23.0190
370158	0.9116	0.8857	22.0056	22.2823	23.6245	22.6374
370166	0.9198	0.8865	26.3420	22.9735	24.2057	24.5051
370169	0.7920	0.8194	24.5389	20.5348	20.0423	21.8107
370170	0.9052	1.4448	*	*	*	*
370171	1.0000	1.4448	*	*	*	*
370172	0.8044	1.4448	*	*	*	*
370173	1.0007	1.4448	*	*	*	*
370176	***	*	26.6687	27.2899	*	26.9843
370178	0.9180	0.8021	15.6720	17.3536	21.1267	17.9566
370180	1.2523	1.4448	*	*	*	*
370183	0.9346	0.8865	30.3850	25.4218	25.6069	27.0496
370190	1.6477	0.8865	32.5635	35.6046	42.6043	37.1575
370192	1.9251	0.8857	19.1346	28.9574	32.6162	27.3260
370196	***	*	24.6984	*	*	24.6984
370199	0.9552	0.8857	23.9376	25.9775	26.7816	25.6697
370200	***	*	19.7060	27.9940	35.8706	26.8167
370201	1.5046	0.8857	25.5882	30.4213	30.8992	28.9168
370202	1.4666	0.8865	25.8261	29.3845	30.9895	28.8517
370203	1.8920	0.8857	30.3641	31.6266	32.1836	31.6700
370206	1.9178	0.8857	30.8151	28.9491	30.0552	29.9046
370210	1.9062	0.8865	25.7905	29.4082	29.9036	28.4550
370211	1.1934	0.8857	30.9656	32.7888	34.7930	33.0107
370212	1.9722	0.8857	20.0919	23.4166	27.1346	23.5285
370214	0.8377	0.8117	20.1495	22.3796	25.0438	22.5257
370215	2.2825	0.8857	32.0950	32.7257	33.2335	32.7249
370216	2.1658	0.8865	29.6658	29.1189	26.1680	28.1238
370218	1.4156	0.8865	23.7517	29.6378	28.7546	27.2705
370219	***	*	41.4392	*	*	41.4392
370220	2.2137	0.8857	21.3168	22.2077	20.9275	21.4193
370222	1.9360	0.8857	26.9175	28.6123	28.3409	27.9641
370223	***	*	24.0154	*	19.5397	21.3964
370224	***	*	*	21.5542	*	21.5542
370225	1.1413	0.8857	*	*	*	*
370226	***	*	*	*	37.1376	37.1376
370227	1.0250	0.8865	*	*	25.9801	25.9801
370228	1.1823	0.8865	*	*	29.2523	29.2523
370229	1.0257	0.8021	*	*	*	*
370231	0.9969	0.8865	*	*	*	*
370232	1.1109	0.8021	*	*	*	*

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)
380001	1.2530	1.1167	33.8490	36.3316	37.7553	36.0264
380002	1.3507	1.0041	32.6830	32.7006	33.7871	33.0690
380004	1.6902	1.1167	36.1021	37.7310	38.7746	37.5359
380005	1.4128	1.0041	33.5765	33.5424	36.4725	34.5228
380007	1.9680	1.1167	36.4222	37.9358	39.2806	37.8806
380009	2.1862	1.1167	36.5688	36.8442	39.1353	37.5601
380014	1.9778	1.0292	35.7101	36.4373	36.1082	36.0941
380017	1.7902	1.1167	36.8103	37.5098	38.6461	37.6712
380018	2.0193	1.0041	32.4884	32.3945	33.4266	32.7871
380020	1.4677	1.1277	35.7392	37.4343	42.4862	38.6492
380021	1.5246	1.1167	33.0628	33.3855	35.2906	33.9321
380022	1.4159	1.0167	30.9181	32.6138	34.0819	32.6070
380025	1.2343	1.1167	38.1507	38.7401	40.2500	39.0966
380027	1.4336	1.0981	31.4398	33.7027	35.3643	33.5318
380029	1.3160	1.1067	33.3368	34.4907	36.3741	34.8137
380033	1.1325	1.1277	36.0798	36.6589	38.8989	37.2559
380037	1.4089	1.1167	34.0321	36.0715	37.8370	36.1213
380038	1.3228	1.1167	35.0350	36.3586	37.3332	36.2453
380040	1.5283	1.0041	34.4500	37.3200	39.0247	37.0479
380047	1.8942	1.0981	35.8165	37.9901	39.2942	37.8116
380050	1.4662	1.0041	31.3088	32.4377	35.4998	33.1733
380051	1.8579	1.1167	35.0114	37.3363	39.5727	37.3318
380052	1.2455	1.0041	27.7656	29.1449	30.5741	29.1620
380056	1.2401	1.1067	31.0210	31.9034	32.2916	31.7191
380060	1.5979	1.1167	35.1106	36.9581	37.6141	36.6186
380061	1.6961	1.1167	35.8922	37.9554	39.8488	37.8849
380071	1.5130	1.1167	31.6821	32.7466	36.1583	33.5280
380075	1.4781	1.0041	34.0197	36.0119	37.8931	35.9406
380082	1.3415	1.1167	37.7268	38.8914	40.5858	39.0672
380089	1.3650	1.1167	37.0017	37.7878	39.3293	38.0923
380090	1.3301	1.0981	41.4540	41.3541	36.1913	39.4809
380091	1.6124	1.1167	39.7431	47.7003	43.5936	43.8353
380100	***	*	45.3882	*	*	45.3882
380102	1.8467	1.1277	*	*	*	*
390001	1.5928	0.8521	25.4188	27.9772	27.1335	26.8080
390002	1.4560	0.8564	25.9827	26.9670	28.0196	26.9876
390003	1.1897	0.8521	26.2872	26.6558	28.5513	27.1586
390004	1.7151	0.9157	26.5054	29.3249	30.1098	28.6330
390006	1.9048	0.9157	30.9914	32.8108	34.0283	32.6962
390008	1.1052	0.8532	22.9417	25.0200	23.3705	23.7755
390009	1.7909	0.8521	29.0286	29.4416	29.4967	29.3239
390010	***	*	26.0966	27.8944	*	26.9767
390012	1.2900	1.0754	34.2004	35.6251	36.5034	35.4478
390013	1.4998	0.9157	28.3039	26.8792	28.6103	27.9367
390016	1.3710	0.8521	26.1802	25.6660	28.5572	26.7918
390019	1.2656	0.9370	25.3185	25.2047	27.4852	25.9661
390023	1.2198	1.0754	36.2618	37.9254	40.0266	38.0609
390024	***	*	37.4815	*	*	37.4815
390025	0.5715	1.0754	*	*	*	*
390026	1.2953	1.0754	36.0608	36.6927	37.8939	36.8734
390027	1.8176	1.0754	40.9110	42.5592	43.2814	42.2597
390028	1.7616	0.8564	29.6218	31.3868	29.7635	30.2408
390030	1.1774	0.9370	26.5678	26.9684	29.2557	27.6192
390031	1.2218	0.8839	26.1258	27.5747	30.8760	28.1332
390032	1.3312	0.8564	25.3756	27.3294	28.0095	26.9149
390035	1.2342	1.0754	27.2130	27.6331	30.7315	28.5818
390036	1.5866	0.8564	26.1956	30.1286	32.9737	29.7215
390037	1.4602	0.8564	27.0788	31.6832	31.5414	30.0425
390039	1.3655	0.8558	22.1531	23.3456	24.9670	23.4732
390041	1.2656	0.8564	25.1190	26.4415	26.5728	26.0705
390042	1.5148	0.8564	29.6213	30.6691	30.9942	30.4327
390043	1.2296	0.8521	24.3590	26.4451	27.6238	26.1517
390044	1.6128	1.0520	29.9959	30.6946	30.4824	30.3991
390045	1.4760	0.8521	25.8800	26.4450	25.4003	25.8945
390046	1.8301	0.9852	32.5273	32.1156	36.5718	33.8376
390048	1.1692	0.9157	28.4563	29.0278	30.0836	29.1873
390049	1.5518	0.9370	31.0290	32.7809	33.6019	32.4920
390050	2.1229	0.8564	29.6715	32.0935	32.6683	31.5002
390052	1.1984	0.8539	26.3700	27.4028	28.0628	27.2991
390054	***	*	27.5696	*	*	27.5696
390056	1.1238	0.8543	24.7038	25.5903	26.1125	25.4737
390057	1.3731	1.0754	31.0279	33.9576	34.1193	33.0155

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)
390058	1.4268	0.9157	29.6620	29.4647	31.4310	30.2148
390061	1.5125	0.9852	30.9208	30.2319	33.2800	31.3667
390062	1.1590	0.8568	22.8856	37.2849	24.7375	28.3022
390063	1.9432	0.8521	28.3987	30.3687	29.6058	29.4589
390065	1.3869	1.0363	31.8841	31.2628	36.2450	33.2337
390066	1.4935	0.9157	29.0033	28.3747	28.4513	28.6007
390067	1.8047	0.9852	32.2891	30.5601	32.6981	31.8514
390068	1.2866	0.9852	29.6984	28.2183	31.3650	29.7338
390070	1.3814	1.0754	34.5501	33.4969	34.4979	34.1825
390071	1.0479	0.8521	26.3830	27.8695	29.4040	27.8628
390072	1.0365	0.8521	28.8145	28.0714	29.2981	28.7468
390073	1.7549	0.8568	27.0876	28.8519	30.6146	28.8321
390076	1.3590	1.0754	33.9908	34.0355	36.0298	34.6424
390079	1.8713	0.8747	26.0199	26.9676	29.0214	27.3470
390080	1.4522	1.0754	31.6210	33.0003	34.7926	33.0747
390081	1.3314	1.0754	36.4788	37.7643	37.7340	37.3382
390084	1.2793	0.8521	24.3191	24.8010	26.7770	25.2792
390086	1.5945	0.8521	24.7454	25.3096	25.8188	25.2998
390090	1.8764	0.8564	30.1256	31.9282	33.7283	31.8662
390091	1.2620	0.8521	23.2118	23.9434	24.9876	24.0592
390093	1.2290	0.8521	23.8846	23.5291	23.4895	23.6334
390095	1.2005	0.8521	25.3859	25.9594	25.8250	25.7143
390096	1.6264	1.0520	30.3910	31.7443	32.9565	31.7301
390097	1.2966	1.0754	28.1285	30.4946	31.2903	29.9555
390100	1.6541	0.9852	32.7836	32.8949	33.8035	33.1878
390101	1.3191	0.9977	25.9850	28.6622	30.5623	28.4487
390102	1.4762	0.8564	25.5336	26.3716	27.4055	26.4607
390104	1.0256	0.8521	20.4552	26.8407	25.5455	24.5825
390107	1.7718	0.8564	25.6790	26.6305	27.5092	26.6474
390108	1.3264	1.0754	34.3066	33.3017	33.0777	33.5645
390110	1.6616	0.8521	25.7159	28.5314	29.2086	27.8363
390111	2.3297	1.0754	37.7322	34.5571	37.4002	36.5374
390112	1.1114	0.8558	18.4185	19.5361	21.7604	19.8894
390113	1.3636	0.8521	24.8669	25.9952	27.3214	26.1018
390114	1.5335	0.8564	28.5336	28.2039	31.1694	29.3405
390115	1.4010	1.0754	32.5058	32.8427	32.4872	32.6127
390116	1.4090	1.0754	33.9295	34.5119	36.0373	34.8498
390117	1.2284	0.8529	22.2327	26.0642	29.4510	25.9013
390118	1.2756	0.8521	23.6535	23.7128	24.9322	24.0922
390119	1.3599	0.8521	25.3907	25.9784	27.7632	26.4233
390122	1.0543	0.8521	24.6434	24.0424	25.6729	24.7743
390123	1.2379	1.0754	35.1244	34.1121	36.2868	35.1756
390125	1.2563	0.8521	24.0199	24.4654	28.2276	25.5392
390127	1.5706	1.0754	33.1227	34.6488	37.2871	35.0064
390128	1.2760	0.8564	25.1858	26.0441	26.6025	25.9602
390130	1.2073	0.8521	30.7083	26.7324	27.8802	28.3933
390131	1.4113	0.8564	27.7146	26.9190	27.7743	27.4667
390132	1.6245	1.0754	30.0751	33.1853	34.6647	32.6191
390133	1.8571	1.0520	33.0604	35.0046	33.5798	33.8910
390137	1.5065	0.8521	26.9156	27.9033	28.8736	27.9111
390138	1.3244	1.0363	27.7565	29.0224	31.9313	29.6083
390139	1.3858	1.0754	36.5001	36.8337	38.9680	37.4654
390142	1.5812	1.0754	33.3509	38.1793	41.5144	37.7887
390145	1.4739	0.8564	26.9212	27.6510	28.4444	27.7016
390146	1.1970	0.8521	23.9878	27.5267	28.6142	26.6764
390147	1.4098	0.8564	29.0995	30.4797	29.8970	29.8246
390150	1.1325	0.8526	22.6483	27.2922	29.5066	26.6113
390151	1.4533	1.0363	31.8967	35.0627	36.1803	34.4556
390153	1.3662	1.0754	36.0287	37.0995	38.6476	37.2956
390154	1.2217	0.8521	23.9785	24.6857	26.5481	25.0921
390156	1.3617	1.0754	33.7057	34.9903	37.3040	35.3176
390157	1.2496	0.8564	23.0989	23.7167	25.3272	24.0518
390160	1.4641	0.8564	25.2043	27.5196	28.6839	27.1696
390162	1.5709	1.1292	35.1844	36.7008	37.4657	36.4170
390163	1.3306	0.8564	24.8761	25.4594	26.9787	25.7948
390164	2.2789	0.8564	29.7778	29.0556	30.3457	29.7271
390166	***	*	28.2178	*	*	28.2178
390168	1.6857	0.8564	27.3674	28.2578	30.9208	28.8813
390169	1.1762	0.8521	26.6063	28.4619	28.7443	27.9880
390173	1.3215	0.8558	27.6039	28.0999	29.4671	28.4203
390174	1.8138	1.0754	35.1118	36.5352	38.5628	36.7614
390176	1.0420	0.8564	*	27.5270	32.1067	29.5896

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390178	1.4445	0.8597	23.9166	25.2325	26.0830	25.0748
390179	1.4701	1.0754	31.5498	33.9916	35.7557	33.8284
390180	1.4303	1.0754	38.2997	37.8677	39.1951	38.4531
390181	***	*	27.8833	*	*	27.8833
390183	1.1887	0.8521	28.2211	28.8361	28.2926	28.4523
390184	1.0458	0.8564	23.9973	24.1461	24.6128	24.2546
390185	1.3942	0.9370	25.5318	28.1346	29.5126	27.8673
390189	1.0954	0.8521	23.4902	25.3686	26.8159	25.2743
390192	1.0196	0.8521	23.7958	24.7427	25.0064	24.5196
390194	1.2336	0.9370	23.7367	27.8231	27.5233	26.2931
390195	1.6061	1.0754	37.2504	36.8626	39.5193	37.8835
390196	1.5301	*	*	*	*	*
390197	1.3716	0.9370	27.7303	28.1999	28.4831	28.1339
390198	1.0016	0.8521	21.0861	21.3574	23.6226	22.0328
390199	1.1525	0.8521	24.5469	24.9642	25.6244	25.0617
390201	1.5511	0.9466	28.5668	28.7755	33.2281	30.2662
390203	1.5230	1.0754	30.7244	33.0056	39.2336	34.4675
390204	1.3951	1.0754	32.0242	33.8120	31.6885	32.4655
390211	1.4122	0.8597	27.7875	28.0796	29.5545	28.4762
390217	1.2688	0.8564	26.2706	25.6917	27.0862	26.3509
390219	1.3817	0.8564	26.3263	27.2812	28.9439	27.5209
390220	1.2574	1.0754	32.0891	33.0323	34.0891	33.0433
390222	1.4380	1.0754	32.7077	34.5835	35.0126	34.1301
390223	2.1413	1.0754	36.5784	35.8030	36.4650	36.2814
390225	1.3671	0.9852	26.3642	*	37.1941	31.3943
390226	1.7682	1.0754	35.4683	35.5564	37.7219	36.2803
390228	1.5300	0.8564	25.5120	28.4321	28.8603	27.5989
390231	1.4535	1.0754	35.2312	35.0675	35.2438	35.1817
390233	1.4332	0.8521	28.3660	29.5938	31.2886	29.7896
390236	1.0294	0.8521	24.5574	25.1866	26.6423	25.4327
390237	1.6878	0.8521	29.9748	29.6917	29.3095	29.6511
390256	1.9907	0.9157	28.5887	31.6455	32.5623	30.9743
390258	1.4564	1.0754	32.0551	33.7330	37.1108	34.3507
390263	1.6615	0.9370	30.2069	31.1718	31.3869	30.9508
390265	1.6237	0.8564	27.7795	27.8241	30.8312	28.8108
390266	1.1383	0.8597	23.0142	23.5248	24.2237	23.5942
390267	1.5021	0.8564	25.7571	28.4250	30.7192	28.2785
390268	1.4705	0.8625	28.4200	30.0652	30.2608	29.6035
390270	1.7441	0.8521	27.0301	29.3622	31.2831	29.3393
390272	0.6330	1.0754	32.9918	29.4836	28.9571	30.3312
390278	0.7864	1.0754	28.8318	33.9596	32.6147	31.7766
390285	***	*	38.4703	43.0793	42.6052	41.2127
390286	***	*	31.7337	32.6998	34.3178	32.9232
390290	1.8432	1.0754	47.7663	41.9121	45.5807	45.0187
390304	1.4348	1.0754	33.4134	35.0741	31.4088	33.2707
390307	1.9281	0.8597	22.9474	27.2053	28.5995	26.1209
390311	***	*	49.9027	*	*	49.9027
390312	1.4452	1.0754	51.3372	42.3481	47.4880	46.6959
390313	1.1402	0.8839	*	27.3018	28.2926	27.7767
390314	1.9104	0.9370	*	*	31.2573	31.2573
390315	***	*	*	*	33.7902	33.7902
390316	2.1098	1.0520	*	*	27.5437	27.5437
390317	0.8038	1.0754	*	*	40.0124	40.0124
390318	1.4192	0.9370	*	*	28.6550	28.6550
390319	0.9481	0.8564	*	*	*	*
390320	2.7965	1.0754	*	*	*	*
390321	1.7804	0.9370	*	*	*	*
400001	1.3274	0.4281	15.4249	15.9192	16.7445	16.0401
400002	***	*	12.9793	14.2946	*	13.6163
400003	1.4027	0.4270	14.6859	15.8816	16.1000	15.5371
400004	1.1337	0.4281	13.5197	14.5542	15.6108	14.5643
400005	1.1494	0.4281	11.7590	12.6516	13.5884	12.6906
400006	1.2753	0.4281	*	*	11.3136	11.3136
400007	1.3194	0.4281	10.4934	10.7767	12.4387	11.1606
400009	1.0496	0.3559	10.1212	14.0016	12.1357	11.8590
400010	0.8029	0.3368	10.4206	12.8584	9.9672	10.7810
400011	1.2081	0.4281	9.4068	10.7620	11.2874	10.4917
400012	1.6634	0.4281	*	11.1553	12.3626	11.7239
400013	1.3877	0.4281	12.3073	12.7900	13.8647	13.0122
400014	1.4610	0.3594	12.3301	11.0722	11.8088	11.7044
400015	1.2566	0.4281	21.9225	17.6943	20.5988	19.9006
400016	1.5854	0.4281	17.9107	19.1577	18.3094	18.4590

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)
400017	***	*	10.0590	*	*	10.0590
400018	1.3636	0.4281	13.1572	13.6091	14.0249	13.6198
400019	1.5566	0.4281	15.2364	15.0604	15.9328	15.3864
400021	1.5607	0.4548	14.9779	16.3677	16.9832	16.1033
400022	1.4793	0.4270	15.2124	15.3660	16.5416	15.6982
400024	0.7732	0.3594	13.7215	14.2708	12.9537	13.5778
400026	1.2407	0.3559	8.9064	9.8155	10.7157	9.7984
400028	***	*	9.6941	11.1923	10.2920	10.3634
400032	1.1343	0.4281	10.7844	11.9013	12.2654	11.6853
400044	1.7300	0.4270	12.1393	13.4579	14.6559	13.6076
400048	1.2979	0.3559	10.5176	11.5766	13.1835	11.7954
400061	2.1704	0.4281	17.4504	18.5327	20.5061	18.8363
400079	1.5588	0.3368	10.6127	11.3550	11.9808	11.3399
400087	1.2640	0.4281	12.0034	12.6233	13.4273	12.6867
400098	1.2431	0.4281	12.8756	13.2365	13.3658	13.1712
400102	1.2316	0.4281	12.1257	12.6314	10.9528	11.7715
400103	2.0761	0.3594	11.3314	12.7285	11.9849	12.0088
400104	1.3358	0.4281	12.6934	12.9616	11.8180	12.5006
400105	1.0711	0.4281	17.0463	25.3823	19.6104	19.9048
400106	1.1191	0.4281	14.8544	14.1766	15.1447	14.7142
400109	1.4847	0.4281	14.5713	15.4910	16.2283	15.4426
400110	1.2368	0.3527	10.8214	11.2311	12.3738	11.4462
400111	1.2060	0.3368	10.7892	11.0467	12.0667	11.3118
400112	1.2379	0.4281	11.2303	9.6181	13.0518	11.1338
400113	1.3390	0.4270	11.5948	11.9672	12.8770	12.1613
400114	1.2113	0.4281	11.6872	11.5514	12.7826	12.0293
400115	1.0598	0.4281	10.6809	12.0201	10.9550	11.2436
400117	1.0324	0.4281	12.1540	12.2159	13.0596	12.4846
400118	1.3323	0.4281	12.6199	13.3983	14.0600	13.3764
400120	1.4734	0.4281	14.5205	14.6591	15.3664	14.8565
400121	1.0669	0.4281	9.9713	11.7462	11.7426	11.2720
400122	2.2443	0.4281	10.0966	13.1851	13.6585	12.0847
400123	1.2369	0.3594	13.8601	13.4317	14.3010	13.8577
400124	2.8599	0.4281	19.1704	21.9082	22.0591	21.0740
400125	1.2425	0.3873	13.1078	12.7141	13.5864	13.1629
400126	1.2276	0.4548	*	14.2108	13.0372	13.5539
400127	2.2024	0.4281	*	12.0796	10.6607	11.1986
400128	1.0442	0.4281	*	23.6366	14.1066	17.2077
410001	1.3296	1.1629	30.5865	30.8038	33.6396	31.6559
410004	1.3994	1.1629	35.2384	33.7118	35.8356	34.9222
410005	1.2979	1.1629	34.2846	38.2842	38.0587	36.9357
410006	1.4558	1.0698	33.9961	35.4462	36.1957	35.2219
410007	1.7064	1.1629	34.4774	37.0287	38.3835	36.6995
410008	1.3757	1.0698	33.6384	34.6138	35.3780	34.5634
410009	1.3355	1.0698	34.3427	36.0892	36.4059	35.6351
410010	1.1199	1.1629	34.9330	38.4603	39.9605	37.7758
410011	1.4645	1.1629	36.7668	38.5007	37.6552	37.6653
410012	1.6248	1.1629	36.5207	37.5223	38.6816	37.5733
410013	1.2620	1.1355	39.8659	38.2253	38.6382	38.8929
420002	1.6629	0.9255	31.2247	32.3569	33.2909	32.2555
420004	2.1010	0.9272	30.0764	31.8610	34.0973	32.1483
420005	1.2940	0.8406	26.5044	28.0173	29.8614	28.1252
420006	2.1518	*	29.1404	31.5368	32.2676	30.9559
420007	1.7111	0.9194	28.9557	31.1080	31.7385	30.6344
420009	1.4017	0.9096	28.6648	29.1084	29.6782	29.1540
420010	1.1694	0.8438	26.5523	27.0435	27.8670	27.1652
420011	1.1720	0.9404	26.0585	25.9484	25.1663	25.7386
420015	1.3418	0.9404	27.4929	27.9759	29.6159	28.3473
420016	1.0027	0.8393	23.4323	23.2125	24.8288	23.8290
420018	1.9284	0.8781	29.0923	28.9660	30.4816	29.5306
420019	1.1621	0.8563	25.8119	23.7910	26.9947	25.5109
420020	1.3033	0.9272	29.2935	28.9093	30.3706	29.5176
420023	1.8241	0.9404	30.4492	31.2602	33.3425	31.8065
420026	1.9124	0.8781	29.5066	31.2504	32.2615	31.0351
420027	1.6300	0.9096	31.3797	30.6779	30.8169	30.9551
420030	1.4921	0.9272	30.3424	31.3260	33.0950	31.5732
420033	1.3463	0.9404	32.4287	33.8157	33.7095	33.3176
420036	1.2688	0.9087	26.3480	27.1715	28.0220	27.1757
420037	1.4064	0.9404	32.7124	33.5291	34.2713	33.5194
420038	1.2847	0.9404	27.1524	29.5673	31.5348	29.4609
420039	1.0619	0.9042	26.3127	24.5270	26.0451	25.6064
420043	1.1861	0.8568	25.8366	24.2727	25.5986	25.2191

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)
420048	1.3049	0.8781	27.4353	29.9094	30.2245	29.2116
420049	1.3260	0.8665	28.0920	28.4801	29.3221	28.6399
420051	1.8299	0.8438	27.6130	28.0711	29.6347	28.4507
420053	1.2963	0.8504	25.4820	26.4997	27.1046	26.3500
420054	1.1210	0.8395	26.7900	27.1580	28.2695	27.4110
420055	1.1416	0.8425	25.3144	25.9899	26.0222	25.7582
420056	1.3094	0.8393	29.7774	27.8175	29.3151	28.9530
420057	1.2963	0.8438	27.7137	29.5662	29.8853	29.0693
420062	1.0833	0.8518	27.2263	28.3129	29.4693	28.3814
420064	1.5616	0.8665	25.0654	26.4352	28.4409	26.6867
420065	1.5441	0.9272	28.1896	28.2922	29.0643	28.5238
420066	0.9570	0.8438	20.5743	26.0307	25.2248	23.7406
420067	1.4142	0.8816	27.7167	29.0379	29.2038	28.6516
420068	1.5378	0.9553	28.0316	28.1555	30.0624	28.7156
420069	1.2850	0.8393	24.4656	25.1993	25.9414	25.2143
420070	1.4122	0.8781	27.6431	28.4000	28.5547	28.2042
420071	1.5208	0.9096	28.1099	28.6098	30.2658	29.0149
420072	1.1647	0.8393	20.7716	24.4951	25.2380	23.5109
420073	1.4865	0.8781	28.2671	29.5999	30.4913	29.4808
420078	1.9867	0.9404	32.8731	34.3181	33.4428	33.5456
420079	1.5363	0.9272	30.5981	31.7686	32.4590	31.6240
420080	1.4096	0.8816	32.8712	33.8785	35.2921	34.0324
420082	1.5126	0.9555	34.8864	33.5290	33.6631	33.9896
420083	1.4791	0.9194	29.6587	29.2264	33.9961	30.8519
420085	1.5196	0.9278	29.9085	31.3391	32.5325	31.2824
420086	1.5308	0.8781	29.6349	30.1406	30.8921	30.2379
420087	1.8321	0.9272	28.4632	28.8860	29.9327	29.1125
420089	1.6898	0.9272	31.7367	33.0906	35.2370	33.3695
420091	1.5567	0.8438	27.9062	28.0471	31.0139	28.9607
420098	1.1976	0.8401	27.6722	28.2058	29.7740	28.6458
420100	***	*	29.2979	*	*	29.2979
420101	1.0052	0.8816	33.1995	33.5957	33.3134	33.3607
420102	1.8906	0.9404	*	*	34.3401	34.3401
420103	1.2387	0.9404	*	*	*	*
430005	1.4208	1.0000	25.4385	27.1759	29.2349	27.2436
430008	1.1323	1.0000	27.2275	27.2961	28.1254	27.5645
430012	1.3663	1.0000	27.0195	28.5808	28.9566	28.1931
430013	1.2067	1.0000	28.4962	28.3679	29.7367	28.8751
430014	1.5187	1.0000	28.9295	29.2921	30.3610	29.5352
430015	1.3611	1.0000	28.0414	28.0093	28.9275	28.3263
430016	1.6144	1.0000	31.1336	31.5894	34.2577	32.4622
430027	1.7295	1.0000	29.2617	29.2432	31.1799	29.9353
430048	1.2480	1.0353	25.6428	26.9537	28.6666	27.1015
430060	0.9026	1.0000	*	11.7801	*	11.7801
430064	0.9703	*	17.7334	*	*	17.7334
430077	1.7929	1.0934	31.1945	35.3480	39.6492	35.3981
430081	1.0199	1.4448	*	*	*	*
430082	0.7513	1.4448	*	*	*	*
430083	1.0550	1.4448	*	*	*	*
430084	0.8832	1.4448	*	*	*	*
430089	2.2827	1.0000	24.9060	28.3217	28.7284	27.4460
430090	2.0301	1.0000	32.7395	33.8350	34.0154	33.5637
430091	2.0885	1.0934	26.7258	28.3496	29.0879	28.0806
430092	2.0494	1.0000	23.2527	26.6750	28.2972	26.0003
430093	0.9808	1.0934	24.7426	30.7398	30.2265	28.4581
430094	1.7420	1.0353	23.6624	23.9005	24.9758	24.2117
430095	2.3107	1.0000	32.5881	31.8141	38.2045	34.0824
430096	2.3728	1.0000	24.9623	28.0608	28.3754	27.0760
440001	1.1423	0.7963	25.4855	23.9380	23.6443	24.3458
440002	1.7402	0.8920	26.9133	28.4828	28.7946	28.0841
440003	1.3257	0.9357	26.0115	31.4162	31.1633	29.3041
440006	1.6645	0.9357	31.7394	32.6924	33.5061	32.7436
440007	1.1248	0.8142	22.7571	23.4825	23.6841	23.3260
440008	1.0281	0.8212	26.8857	26.2003	28.2848	27.1384
440009	1.1708	0.7963	24.4423	25.1184	26.0011	25.1825
440010	0.9243	0.7963	20.2497	23.8087	24.8994	22.8402
440011	1.4425	0.7963	24.8300	25.7912	27.1575	25.9494
440012	1.5952	0.7972	24.9261	26.2076	26.5928	25.9387
440015	1.9977	0.7963	27.1603	28.1389	28.4985	27.9418
440016	1.0765	0.8043	25.2512	25.4197	27.4902	26.0443
440017	1.8177	0.7972	26.1820	28.6110	27.1050	27.3226
440018	1.1740	0.7963	24.8568	26.0748	26.3679	25.7848

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)
440019	***	*	26.2464	28.0387	30.3600	28.1304
440020	1.0657	0.7963	27.5626	28.0269	29.6906	28.3990
440024	***	*	26.2534	25.4398	*	25.8750
440025	1.2561	0.8434	24.0289	25.5605	26.7608	25.4751
440026	***	*	28.4615	26.5911	29.9483	28.3607
440029	1.4714	0.9357	31.4652	31.8872	32.1031	31.8341
440030	1.3554	0.7963	22.3144	23.1116	23.2548	22.8983
440031	1.2845	0.7963	22.0711	23.0937	24.1953	23.1179
440032	1.2903	0.7963	23.8030	25.4122	25.3178	24.8762
440033	1.1176	0.7963	23.9792	24.3197	24.6594	24.3303
440034	1.7491	0.7963	25.9138	26.7987	27.0814	26.6024
440035	1.3762	0.9245	27.9217	26.8725	27.7654	27.5174
440039	2.2785	0.9357	30.1918	32.4190	32.9809	31.8914
440040	0.8602	0.7963	21.1288	21.3795	23.0096	21.8141
440046	1.5007	0.9357	30.7334	31.5146	33.1817	31.8211
440047	0.9783	0.8151	25.2150	26.8032	28.6677	26.9097
440048	1.8888	0.9244	30.6725	31.5584	33.6741	31.9580
440049	1.7063	0.9244	29.8623	31.7148	32.6315	31.4044
440050	1.4510	0.7972	26.3825	27.1284	29.3280	27.5649
440051	0.9297	0.8008	23.6560	23.1773	24.8012	23.8852
440052	1.0648	*	24.4071	28.1868	*	26.2378
440053	1.3950	0.9357	30.3907	31.3189	32.4468	31.4068
440054	1.2435	0.7963	21.9641	25.7785	25.9340	24.4618
440056	1.2204	0.7963	24.0635	25.2050	26.0579	25.1205
440057	1.1740	0.7963	19.3546	25.1519	22.9202	22.2778
440058	1.1492	0.8620	29.1184	28.5093	29.0781	28.9051
440059	1.5321	0.9245	29.4532	30.4489	30.5956	30.1889
440060	1.3363	0.8151	26.5867	26.5518	27.2994	26.8199
440061	1.1152	0.7963	25.4134	25.9969	26.5183	25.9921
440063	1.7344	0.7996	26.0763	25.4344	28.7331	26.7457
440064	0.9734	0.8837	26.7957	26.9014	28.8691	27.5266
440065	1.4389	0.9357	25.6111	27.3501	27.6293	26.8695
440067	1.0879	0.7963	26.0866	26.5062	27.4576	26.6914
440068	1.1836	0.8635	27.9082	27.2646	28.8471	28.0140
440070	0.9667	0.8023	23.2228	24.4477	23.7541	23.8052
440072	1.1077	0.7963	26.1661	27.6990	29.4589	27.8052
440073	1.4586	0.9245	27.5133	28.3950	33.8204	29.7934
440081	1.3267	0.7963	21.9681	23.3000	24.5308	23.2815
440082	1.9820	0.9357	32.8941	34.4535	34.2234	33.8153
440083	0.9678	0.7963	25.7074	25.5397	31.8091	27.4016
440084	1.1913	0.7963	19.8950	21.3873	21.0886	20.7933
440091	1.8112	0.8837	28.9697	30.0650	31.5967	30.2362
440102	1.0781	0.7963	22.1114	23.5525	24.5092	23.3345
440104	2.0266	0.8837	28.0905	29.7326	30.5868	29.4920
440105	0.9050	0.7996	23.7154	24.6039	25.1516	24.4868
440109	1.0319	0.8002	22.5878	23.8465	25.0293	23.8740
440110	1.2059	0.7963	23.6275	23.8010	24.8508	24.1158
440111	1.3708	0.9357	29.7461	33.0828	34.7986	32.5032
440115	1.0246	0.8151	24.9778	25.2508	26.5043	25.5819
440120	1.5835	0.7963	26.0621	28.0271	29.3763	27.8414
440125	1.7354	0.7963	24.0934	24.7908	25.8923	24.9302
440130	1.1307	0.7963	26.3192	27.5525	29.7486	27.8856
440131	1.1097	0.9244	28.3162	29.0546	29.6113	29.0016
440132	1.2404	0.7963	29.3377	26.1823	26.0002	27.0734
440133	1.7764	0.9357	32.5726	33.2319	32.4606	32.7474
440135	***	*	27.2094	28.7658	*	27.7843
440137	1.1024	0.8568	24.6143	25.6931	26.9344	25.7232
440141	1.0666	0.7963	24.8737	24.3575	26.3648	25.1490
440144	1.2612	0.8635	26.3225	26.6282	28.1488	27.0243
440147	***	*	36.6978	33.5900	37.7400	36.1480
440148	1.2607	0.8205	28.0708	26.2483	26.9317	27.0777
440150	1.5299	0.9357	30.5513	32.9854	33.1069	32.2368
440151	1.2054	0.9245	28.6585	28.8412	29.7047	29.0648
440152	2.5625	0.9244	29.0588	28.7357	30.4975	29.4397
440153	1.0707	0.7963	23.3790	23.8797	25.5029	24.2277
440156	1.6720	0.8837	30.5161	31.0506	32.1008	31.2372
440159	1.4664	0.9244	27.2785	26.2728	29.3482	27.6162
440161	2.1078	0.9357	31.0667	32.2343	33.5505	32.3178
440162	***	*	24.6425	27.8605	32.8676	28.1996
440168	0.9044	0.9244	31.3316	37.0865	35.6029	34.6178
440173	1.5174	0.7963	23.1370	23.5486	24.5146	23.7547
440174	0.9085	0.8920	27.4579	27.4578	29.2110	28.0210

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440175	1.0307	0.7963	26.7705	29.2713	29.4314	28.4751
440176	1.4968	0.7972	24.9420	26.1477	25.9945	25.7062
440180	1.1625	0.7963	24.3376	26.9310	28.0103	26.4461
440181	1.1717	0.8269	26.4763	26.2247	26.7981	26.5048
440182	0.9173	0.8043	24.9899	24.4173	26.1103	25.1663
440183	1.5613	0.9244	30.9923	31.9159	33.2829	32.0510
440184	1.1262	0.7996	26.9086	25.3287	23.3569	24.9974
440185	1.2332	0.8635	26.3974	25.6005	27.2095	26.4371
440186	0.9656	0.9357	28.2840	30.0775	29.4191	29.3763
440187	1.1201	0.7963	27.4034	27.2669	30.0843	28.2507
440189	1.3670	0.8337	30.5786	29.9065	32.4748	31.0649
440192	1.1026	0.9245	30.6533	32.0772	30.3981	31.0167
440193	1.4241	0.9357	25.9726	27.8132	29.1980	27.6564
440194	1.3855	0.9357	32.3020	32.1073	33.8057	32.7738
440197	1.5649	0.9357	31.4317	32.3241	33.5949	32.4391
440200	1.1684	0.9357	23.8288	23.3049	25.6778	24.2873
440217	***	*	31.6650	33.8684	33.9396	33.1510
440218	2.3018	0.9357	36.9273	31.7847	34.8529	34.3045
440222	***	*	30.5148	32.4230	33.4755	32.1333
440225	0.8351	0.7963	26.9687	29.8273	33.1790	30.3095
440226	1.8051	0.7963	28.3199	28.4491	29.7898	28.8667
440227	1.4445	0.9357	31.9119	32.1862	33.3012	32.4842
440228	1.5313	0.9244	29.5372	31.2049	32.7192	31.2575
450002	1.5584	0.8555	29.7180	30.0562	31.6245	30.4316
450005	1.2589	0.8418	27.3473	27.9825	28.6396	28.0229
450007	1.2745	0.9030	24.4630	26.2568	27.8975	26.2399
450008	1.3007	0.8833	24.4372	26.1215	28.5461	26.3285
450010	1.6966	0.9883	30.1034	32.9053	35.9519	32.9306
450011	1.6446	0.9202	29.9302	30.9903	32.9840	31.3000
450015	1.7472	0.9716	30.3168	30.3228	30.4874	30.3766
450018	1.7997	0.9902	31.3131	32.9922	35.5658	33.2947
450021	2.0024	0.9716	31.7360	34.5462	35.7272	34.0279
450023	1.3908	0.8002	25.1683	25.6361	27.9955	26.2970
450024	1.7757	0.8555	27.3814	27.8816	27.1898	27.4818
450028	1.6425	0.9442	29.5689	29.8049	34.0949	31.2107
450029	1.5534	0.8274	28.6465	27.2662	28.3746	28.0917

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)
450031	***	*	29.2141	28.8891	34.0065	30.5751
450032	1.3782	0.8549	26.3159	25.7989	24.7700	25.5851
450033	1.6415	0.9442	29.7668	31.6557	32.7632	31.4296
450034	1.5659	0.8418	29.6309	28.2761	30.5025	29.4195
450035	1.7041	0.9902	30.3369	30.8574	*	30.5883
450037	1.5611	0.8549	28.2622	26.8661	31.6293	28.8475
450039	1.6804	0.9561	29.8145	29.5097	31.1506	30.1895
450040	1.7943	0.8899	28.5469	30.0844	31.7842	30.1150
450042	1.7837	0.8609	27.6131	28.3649	29.9554	28.7231
450044	1.7955	0.9716	32.9921	36.3786	36.8303	35.4308
450046	1.6799	0.8537	27.2439	28.4297	29.1084	28.2772
450047	***	*	24.9670	24.6290	*	24.8091
450051	2.0476	0.9716	30.3976	31.0740	32.5548	31.3439
450052	1.1232	0.7976	24.3964	25.8142	26.8740	25.6882
450054	1.8685	0.8833	30.2211	30.7196	31.8122	30.9775
450055	0.9581	0.7976	24.1418	24.6436	24.1303	24.3050
450056	1.7335	0.9480	32.0902	33.7634	35.1718	33.7262
450058	1.6760	0.9030	27.7318	27.8963	29.3001	28.3568
450059	***	*	28.5645	29.9336	30.4219	29.6605
450064	1.6215	0.9561	29.0495	30.6704	31.2884	30.3625
450068	2.2983	0.9902	32.0372	34.9179	36.0855	34.3935
450072	1.2590	0.9902	28.0921	28.7063	30.1876	29.0662
450073	0.8084	0.7976	22.2322	23.1471	27.3565	24.1117
450076	1.7389	*	*	*	*	*
450078	0.9125	0.7976	20.7800	21.0876	22.8742	21.5764
450079	1.5567	0.9716	36.8936	34.1533	35.0887	35.3290
450080	1.2802	0.9561	26.8111	28.6334	28.2802	27.9091
450082	1.2045	0.7976	25.5654	27.1314	28.0655	26.8213
450083	1.8349	0.8221	30.2054	28.6628	27.8710	28.9043
450085	1.1963	0.7976	26.3610	28.1669	28.9395	27.8176
450087	1.5252	0.9561	32.6556	34.2493	35.5877	34.2069
450090	1.3411	0.8687	22.7822	22.2148	21.6976	22.2179
450092	1.4103	0.8274	28.2278	28.3891	30.5277	29.0923
450097	1.5643	0.9902	31.9782	33.8910	34.3559	33.4316
450099	1.3224	0.8396	29.8491	25.5799	25.4351	26.8724
450101	1.6811	0.8609	28.4220	29.3777	30.4787	29.3971

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)
450102	1.7949	0.8221	27.3364	27.5145	28.5246	27.8109
450104	1.2249	0.9030	27.7851	30.4631	31.5797	29.9109
450107	1.7114	0.8555	29.0328	29.6790	31.5433	30.1261
450108	1.1643	0.9030	22.4293	21.7619	23.4633	22.5501
450119	1.6775	0.8847	34.4161	31.0699	34.4191	33.3584
450123	1.0012	0.8418	24.0433	27.6445	25.6385	25.8672
450124	1.8454	0.9480	31.9797	32.9774	34.3880	33.0146
450126	***	*	32.0370	32.9729	33.9588	33.0168
450128	1.3469	0.8847	28.3171	28.9733	25.6039	27.5138
450130	1.2316	0.9030	26.9208	28.3786	29.4991	28.2579
450132	1.6455	0.9382	31.1361	34.8719	33.2719	33.1069
450133	1.6806	0.9510	30.9622	31.3911	33.3018	31.9167
450135	1.7157	0.9561	30.7909	30.8734	32.1685	31.2956
450137	1.6678	0.9561	35.7775	33.8235	36.3787	35.3088
450143	1.0086	0.9480	24.4346	25.1702	26.2283	25.2751
450144	0.8810	0.9510	31.1552	31.4041	33.9255	32.1336
450147	1.4830	0.8537	26.3032	27.3607	28.1834	27.2665
450148	1.3368	0.9561	30.0542	29.9522	32.0283	30.7178
450151	***	*	22.8768	*	*	22.8768
450152	1.2507	0.8833	24.3442	25.7523	27.2955	25.8863
450154	1.3577	0.7976	24.2582	23.2210	26.8001	24.6416
450155	0.9518	0.7976	24.8773	25.2546	27.0233	25.7416
450162	1.1826	0.8899	33.7823	27.1453	27.1852	29.3968
450163	1.0821	0.8092	27.0967	27.6273	28.6701	27.7991
450165	1.1390	0.9030	30.2236	30.3796	31.6184	30.7499
450176	1.6011	0.8847	25.8587	28.4561	29.1328	27.9364
450177	1.1127	0.7976	26.0895	27.7791	28.4994	27.4696
450178	0.9348	0.9228	28.5990	27.5779	28.9495	28.3698
450184	1.7708	0.9902	30.9726	32.7090	34.0895	32.6044
450187	1.1680	0.9902	29.2749	29.3048	32.4932	30.4061
450188	0.9030	0.7976	24.6823	23.0844	23.4998	23.7692
450191	1.2449	0.9480	31.1339	30.0686	32.6083	31.2533
450192	1.0167	0.8292	26.9884	27.5539	29.0912	27.8965
450193	2.2410	0.9902	37.1906	38.2891	38.8644	38.1234
450194	1.2453	0.8029	30.4381	28.6816	28.5715	29.3145
450196	1.4787	0.9561	25.4842	29.8107	34.5553	29.7850

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)
450200	1.5357	0.7976	27.9843	27.5112	27.4323	27.6497
450201	***	*	22.5464	*	*	22.5464
450203	1.3080	0.9384	28.0986	29.4706	30.6920	29.4190
450209	1.8635	0.8534	31.9882	30.4150	32.0084	31.4487
450210	1.0230	0.8104	22.9055	23.7777	24.1055	23.5562
450211	1.4423	0.8549	28.8485	27.7427	28.6171	28.3845
450213	1.9743	0.9030	28.0307	29.2061	31.8732	29.7718
450214	1.2952	0.9902	28.2261	27.0761	29.6977	28.2450
450219	0.9672	0.7976	24.7274	28.0584	26.5400	26.4052
450221	1.0166	0.7976	20.7118	23.9462	26.0519	23.4298
450222	1.8038	0.9902	31.9255	33.2164	35.4268	33.5487
450224	1.3332	0.8221	28.7931	29.8428	34.2862	30.7480
450229	1.6776	0.8377	26.8039	27.2189	28.6777	27.5770
450231	1.7396	0.8534	27.0545	27.7289	29.0423	27.9547
450234	1.1803	0.7976	21.6799	23.2715	24.5702	23.0910
450235	0.9372	0.7976	23.8001	24.3335	26.5446	24.8864
450236	1.2391	0.8402	24.5942	24.1409	24.7346	24.4942
450237	1.6644	0.9030	31.2197	36.8412	38.6952	35.7632
450239	0.9838	*	18.4234	19.1203	*	18.7784
450241	1.0529	0.7976	28.4948	24.3518	23.6431	25.3628
450243	1.0338	0.7976	19.0180	19.9804	19.3302	19.4414
450253	0.8658	0.9902	22.9918	24.3618	24.8434	24.0803
450270	1.2977	0.8292	12.9999	19.0341	23.1572	17.6860
450271	1.3816	0.9384	23.9534	27.4614	27.2299	26.3217
450272	1.2457	0.9480	29.0917	29.5124	30.9325	29.8676
450280	1.6447	0.9716	34.9349	33.8297	36.7719	35.1881
450283	1.1064	0.9561	28.2094	24.3428	26.0883	26.1050
450289	1.5582	0.9902	32.6137	32.4591	33.0678	32.7196
450292	1.2182	0.9716	29.0243	29.2485	29.9323	29.4201
450293	0.7961	0.7976	24.1556	23.7577	24.0578	23.9922
450296	1.0761	0.9902	33.4545	34.1708	36.4553	34.6803
450299	1.6942	0.9202	29.4593	30.3493	31.1203	30.4009
450306	0.8749	0.8377	22.6818	25.9877	26.8133	25.0737
450315	2.1271	0.9716	31.4227	32.3840	33.7804	32.7196
450324	1.6326	0.9561	27.9899	26.8023	29.4512	28.0893
450330	1.3508	0.9902	27.7419	29.4471	30.3216	29.1449

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)
450340	1.4176	0.8441	29.6617	28.7672	30.5786	29.6830
450346	1.5986	0.8418	24.8434	26.7809	28.3048	26.7142
450347	1.2930	0.9902	28.5789	30.0644	39.0841	31.7610
450348	0.8857	0.7976	22.6828	23.1190	24.9758	23.5712
450351	1.1747	0.9384	29.9598	30.3441	31.5305	30.6253
450352	1.1455	0.9716	27.6480	29.3516	30.7596	29.2838
450358	2.1150	0.9902	33.9103	36.9859	37.7122	36.2645
450369	0.8990	0.7976	24.1953	22.7433	26.2214	24.2062
450370	1.1848	0.9902	29.0816	28.8348	29.9644	29.2842
450372	1.3896	0.9716	30.9345	33.7023	35.7039	33.4631
450373	0.8488	0.7976	27.4251	25.3691	24.2910	25.7184
450378	***	*	33.0583	33.9891	36.4028	34.4190
450379	1.4175	0.9716	35.0637	35.9067	32.6220	34.4723
450388	1.7639	0.9030	29.5386	30.3720	31.6031	30.5169
450389	1.2142	0.9561	26.8499	24.6733	25.7331	25.7506
450393	***	*	39.0266	12.9286	27.1077	24.0523
450395	1.1582	0.8448	28.4272	27.2714	29.8801	28.5709
450399	0.8847	0.7976	20.6307	23.2716	22.6764	22.2006
450400	1.0362	0.9202	29.5020	29.8965	31.2698	30.2436
450403	1.5366	0.9716	31.7065	33.1710	35.4740	33.5099
450411	1.0111	0.7976	21.7877	20.9108	22.4082	21.7011
450419	1.3410	0.9561	34.9972	33.6834	34.9715	34.5434
450422	1.2762	0.9716	32.4669	36.7309	34.1081	34.3563
450424	1.5450	0.9902	29.8290	32.4674	34.5504	32.2992
450431	1.7403	0.9480	28.5289	29.6446	30.6617	29.6315
450438	1.3139	0.9902	27.7734	25.1006	25.4661	26.1356
450446	0.8334	0.9902	15.4641	12.4405	15.5196	14.4414
450447	1.1936	0.9561	28.3724	29.9936	31.8907	29.9923
450451	1.0730	0.8500	25.8836	26.5422	31.4796	27.8667
450460	0.8984	0.8032	25.2165	27.6224	25.4729	26.1109
450462	1.7382	0.9716	30.6516	31.7311	33.7956	32.0428
450465	1.2421	0.9902	28.1853	28.0105	30.1918	28.7989
450469	1.5261	0.9561	31.1348	29.2172	29.6166	29.9812
450475	1.1705	0.8549	24.7037	25.0642	25.7501	25.1898
450484	1.5134	0.8549	27.7792	29.4306	31.9673	29.7483
450488	1.1850	0.8549	24.9109	26.6089	18.8079	23.9994

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)
450489	1.0148	0.7976	26.9543	25.3695	27.9810	26.7310
450497	1.0021	0.8492	23.0712	24.6056	25.2174	24.3019
450498	0.9124	0.7976	20.6873	19.3077	20.7486	20.2110
450508	1.4192	0.8549	29.1519	30.4829	31.5763	30.4250
450514	***	*	26.4196	*	*	26.4196
450518	1.4458	0.8418	27.5880	28.9969	30.5861	29.0751
450530	1.3988	0.9902	30.7745	31.5033	33.7631	32.0263
450537	1.6268	0.9716	30.9167	33.1500	33.2758	32.4450
450539	1.2570	0.8115	25.0191	25.5268	27.9096	26.1671
450547	0.9127	0.9561	25.4140	24.6575	25.2745	25.1196
450558	1.7520	0.8377	28.7747	30.9433	32.3315	30.6879
450563	1.5978	0.9561	32.6875	35.8856	35.5229	34.6980
450565	1.3413	0.9384	27.4774	28.0400	20.2579	24.6765
450571	1.6736	0.8441	26.5313	26.2046	29.0235	27.1983
450573	1.0624	0.8109	24.6750	28.8508	27.5660	27.0761
450578	0.9388	0.7976	25.2478	25.7938	24.6906	25.2293
450580	0.9863	0.7976	25.9881	23.7932	24.3329	24.7319
450584	1.0404	0.7976	23.6044	23.7329	23.9252	23.7516
450586	1.0322	0.7976	18.3289	19.8656	21.2385	19.8409
450587	1.1286	0.7976	25.9364	27.1505	29.0064	27.3358
450591	1.2132	0.9902	27.9867	26.8802	27.3199	27.3923
450596	1.3215	0.9384	31.6590	30.9701	32.6411	31.7668
450597	0.9543	0.7980	24.8443	26.3300	28.5306	26.5836
450604	1.5282	0.9030	29.1543	27.9983	29.6679	28.9307
450605	1.0389	0.8537	14.8039	23.3169	25.9264	19.8597
450610	1.6708	0.9902	30.5977	32.1314	33.4138	32.0218
450615	0.9227	0.8009	22.6331	25.1269	24.9016	24.2168
450617	1.6748	0.9902	30.2923	31.5691	32.8482	31.6179
450620	0.8835	0.7976	21.2535	21.7871	21.8083	21.6167
450630	1.5995	0.9902	31.8014	32.3195	33.9693	32.6628
450634	1.6926	0.9716	31.8008	31.9667	35.0451	32.9458
450638	1.7216	0.9902	33.3237	34.1802	33.8557	33.7790
450639	1.5533	0.9561	34.3754	33.3962	35.2199	34.3232
450641	0.9255	0.8492	21.7292	20.0231	21.9175	21.2226
450643	1.4481	0.8274	27.2538	28.7747	28.9714	28.3454
450644	1.6896	0.9902	31.6874	33.5265	34.8420	33.3732

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)
450646	1.6538	0.8555	27.4631	27.8352	29.9283	28.4230
450647	1.9676	0.9716	34.1016	35.2696	36.5322	35.3409
450651	1.6423	0.9716	33.6498	34.9917	35.6581	34.7059
450653	1.1352	0.7976	26.5361	27.8569	30.2606	28.1926
450654	0.9530	0.7976	25.0755	23.5856	24.5592	24.3762
450656	1.4433	0.8549	29.7290	30.0651	32.2745	30.6394
450658	1.0226	0.7976	22.7090	21.8183	23.5424	22.6645
450659	1.6318	0.9902	34.2657	35.0007	37.3995	35.4274
450661	1.6239	0.9382	29.2381	29.1701	32.8459	30.5668
450662	1.7067	0.9442	30.9630	32.8936	34.5827	32.8459
450668	1.5975	0.8555	30.2083	30.7673	32.0331	30.9602
450669	1.2140	0.9716	32.1244	32.6777	35.4301	33.3979
450670	1.6341	0.9902	26.2954	28.8285	30.2996	28.5154
450672	1.8489	0.9561	33.0858	34.5171	35.3265	34.3331
450674	0.9275	0.9902	31.9316	33.4719	34.3659	33.2921
450675	1.5462	0.9561	32.6380	34.4049	35.3574	34.1552
450677	1.3956	0.9561	27.1603	29.5819	31.0690	29.3302
450678	1.6140	0.9716	33.5513	33.6167	35.3981	34.2049
450683	1.2254	0.9716	24.8440	28.7984	29.3755	27.6744
450684	1.5209	0.9902	31.2765	31.8794	35.0730	32.7027
450686	1.7733	0.8899	26.4871	28.8211	30.3904	28.6455
450688	1.5690	0.9716	29.4393	30.4156	39.5154	33.4913
450690	1.4264	0.8221	30.0577	31.8607	33.2073	31.5411
450694	1.1250	0.7976	27.0862	28.3456	29.6336	28.3300
450697	1.6210	0.9030	28.3002	29.0148	30.4425	29.3072
450698	0.9036	0.8240	23.3062	21.5450	22.3595	22.2972
450702	1.6646	0.8549	27.1318	26.9753	30.2583	28.1054
450709	1.5374	0.9902	31.3239	31.0331	32.2069	31.5516
450711	1.6479	0.8847	28.1040	29.2934	31.1794	29.5120
450713	1.7474	0.9480	30.4933	31.3274	32.4751	31.4774
450715	***	*	*	27.0982	*	27.0982
450716	1.4846	0.9902	33.9926	33.4960	35.7221	34.4016
450718	1.6829	0.9480	29.7609	30.6623	32.6737	31.1358
450723	1.5586	0.9716	31.0481	32.1316	32.6623	31.9557
450730	1.5137	0.9716	32.8920	34.9137	33.1851	33.6209
450742	1.2662	0.9716	30.4204	31.4270	33.0428	31.6346
450743	1.4816	0.9716	29.5098	30.3302	31.3215	30.4331
450746	1.1292	0.7976	23.3484	22.7535	25.0663	23.7082
450747	1.2515	0.8221	28.3935	27.1975	28.8823	28.1480
450749	0.9107	0.7976	23.9269	23.0265	23.2704	23.4132
450754	0.9768	0.7976	22.8572	23.4607	24.3084	23.5573
450755	1.0767	0.8551	24.7428	22.4195	31.3177	25.7520
450758	***	*	28.3305	29.5013	28.1978	28.6502
450760	***	*	23.7157	24.0691	25.7747	24.3535
450766	1.9556	0.9716	31.2084	33.3435	35.1643	33.2460
450770	1.3684	0.9480	23.6093	25.5863	18.0436	22.2510
450771	1.6045	0.9716	32.5014	32.6206	33.8969	33.0354
450774	1.6654	0.9902	27.5065	29.1151	38.3717	31.5427
450775	1.5260	0.9902	31.6656	33.1582	34.3607	33.1074
450779	1.4365	0.9561	32.0770	31.4350	31.9558	31.8166
450780	2.1639	0.9030	28.5560	29.4960	31.6515	29.8696
450788	1.6154	0.8537	29.7667	31.5593	32.7644	31.3687
450795	1.1190	0.9902	43.8574	31.1871	28.4765	34.7221
450796	2.6228	0.8534	39.4762	31.6590	33.6139	34.7494
450797	1.7663	0.9902	26.0302	29.7074	31.7677	29.3047
450801	1.6105	0.7976	25.6379	27.2635	27.2012	26.7141
450803	1.3194	0.9902	28.7041	28.4345	33.0093	29.9054
450804	2.0163	0.9902	31.1891	33.2767	34.1912	32.9223
450808	2.3057	0.9480	29.6476	27.4132	29.9021	29.0161
450809	1.7258	0.9480	29.4696	30.4031	31.4549	30.4823
450811	***	*	31.3007	32.5513	31.9817	31.9430
450813	1.1372	0.8007	26.5803	24.0804	20.6690	23.5607
450820	1.7477	0.9902	34.7445	36.4796	38.2036	36.6052
450822	1.3504	0.9716	34.4060	34.7760	36.6629	35.3196
450824	2.6197	0.9480	31.8413	34.8301	39.0150	35.1974
450825	1.6530	0.8847	25.8006	23.6674	24.3261	24.5712
450827	1.4304	0.9883	24.3659	23.6628	23.9459	23.9864
450828	1.3734	0.7976	26.9553	26.3231	28.2601	27.1671
450830	0.9681	*	28.4007	*	*	28.4007
450831	1.7089	0.9902	24.4141	24.2732	29.1511	25.8366
450832	1.5453	0.9902	28.1389	31.2830	32.4788	30.7537
450833	1.1420	0.9716	29.0256	30.3604	32.7455	30.8526

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)
450834	1.7933	0.9202	26.7253	28.1564	29.0998	27.9215
450838	***	*	19.2949	20.3039	19.0464	19.5627
450839	1.0081	0.7976	27.5330	28.0060	28.5858	28.0243
450840	1.2748	0.9716	32.4162	34.1412	35.8685	34.2949
450841	1.6187	0.9442	24.4389	24.6321	23.9643	24.3356
450844	1.4764	0.9902	33.0758	34.7070	36.5303	34.8330
450845	1.8367	0.8555	28.5039	30.9556	31.2367	30.2196
450847	1.3939	0.9902	30.7431	31.6028	32.1831	31.6082
450848	1.4727	0.9902	31.1476	32.0471	33.4123	32.3010
450850	***	*	27.2653	*	*	27.2653
450851	2.0867	0.9716	32.8377	35.2085	38.8761	35.5609
450853	2.0083	0.9716	38.3600	37.5237	36.5047	37.2093
450855	1.8608	0.9442	30.7353	33.0196	32.9067	32.1821
450856	2.5479	0.9030	35.5006	35.5221	33.9235	34.9286
450860	1.8566	0.9902	33.3404	36.0060	39.5300	36.4507
450862	1.8415	0.9902	33.7962	34.2163	35.3942	34.5203
450864	2.6098	0.8221	25.3535	26.6579	27.1175	26.4340
450865	1.1060	0.9480	31.9200	34.6338	35.8478	34.1908
450867	1.2922	0.9480	31.4953	33.8712	34.7615	33.3961
450868	***	*	27.7501	28.4524	30.9079	29.0584
450869	1.9926	0.8847	28.7422	27.9532	33.2089	30.1383
450871	1.9451	0.9480	32.3990	35.2470	37.9661	35.1767
450872	1.3983	0.9561	31.7345	30.7510	30.9690	31.1226
450874	1.8676	0.9716	35.6839	37.4432	36.9932	36.7503
450875	1.9516	0.8534	23.2962	26.9904	20.1639	22.8101
450876	1.7122	0.8899	30.3515	30.7721	30.9774	30.7049
450877	1.5299	0.8555	29.2353	28.0504	28.0155	28.4092
450878	2.5973	0.9030	33.6269	33.5225	36.1269	34.4596
450879	***	*	36.4874	31.1510	33.9507	33.6678
450880	1.9228	0.9561	32.6713	32.1245	34.4267	33.1581
450883	1.9373	0.9716	37.1525	38.5954	37.2993	37.6825
450884	1.0402	0.8549	23.5799	25.0230	25.7615	24.7946
450885	1.5264	0.9716	36.0954	33.7612	36.0638	35.3112
450886	2.1922	0.9561	30.1571	33.2011	34.2473	32.5767
450887	***	*	25.5590	*	*	25.5590
450888	1.9205	0.9438	28.5995	26.3027	33.6679	29.5932

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)
450889	1.3218	0.9716	35.6151	29.1149	37.7726	33.7871
450890	1.6403	0.9716	32.2000	33.9068	35.5486	34.0550
450891	1.8038	0.9716	39.0890	29.7832	28.6657	31.5415
450892	***	*	39.5333	*	*	39.5333
450893	1.6541	0.9716	36.2660	37.8279	38.4846	37.6086
450894	2.5125	0.9716	25.9441	34.3388	30.1167	30.2576
460001	2.0520	0.9204	30.7040	32.3262	33.1178	32.1009
460003	1.6576	0.9316	29.6450	31.8128	33.2273	31.5385
460004	1.8788	0.9316	29.8773	32.2759	33.1780	31.8212
460005	1.5680	0.9316	29.4188	29.6947	32.5488	30.5734
460006	1.7333	0.9316	28.9653	30.3798	31.5132	30.3350
460007	1.3358	0.9265	29.1191	30.8583	31.3933	30.5233
460008	***	*	27.6906	30.5351	31.2678	29.8189
460009	2.0509	0.9316	29.4705	31.5120	32.4881	31.2048
460010	2.0371	0.9316	30.9813	32.8157	33.5658	32.4980
460011	1.3290	0.8670	26.5486	27.0189	29.7461	27.7667
460013	1.5423	0.9204	29.7252	31.2945	33.2606	31.4104
460014	1.1697	0.9316	30.6450	30.0229	31.5853	30.7595
460015	1.4935	0.8798	28.8014	30.7369	31.4815	30.3797
460017	1.3823	0.8899	28.7126	29.8556	32.9883	30.5236
460018	1.0014	*	22.0935	24.7761	*	23.4535
460019	1.1788	0.8670	25.1615	24.9579	29.0310	26.4212
460021	1.9540	0.9265	29.7397	31.5207	32.5036	31.3081
460023	1.4134	0.9204	28.9473	30.5888	31.3302	30.3452
460026	0.9596	0.9203	29.2775	31.3552	32.2621	30.9954
460030	1.1661	0.8670	26.8979	30.0714	29.9242	28.9826
460033	0.9059	0.8670	27.9108	29.0346	30.0589	29.0233
460035	0.9434	0.8670	23.8682	23.4736	25.1938	24.1852
460039	1.1592	0.9307	30.0677	32.8010	34.9978	32.6843
460041	1.4984	0.9316	26.7356	29.4568	30.8857	29.0170
460042	1.5807	0.9316	36.2903	35.5686	32.2993	34.4935
460043	0.8631	0.9204	29.5660	31.2717	32.7441	31.2599
460044	1.4132	0.9316	29.5079	31.4469	32.6611	31.2578
460047	1.7647	0.9316	31.0020	33.0291	35.1221	33.0258
460049	2.1169	0.9316	28.6267	32.0329	32.9610	31.2660
460051	1.5507	0.9316	28.1140	28.6559	29.4726	28.9574

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)
460052	1.7033	0.9204	28.7455	30.2613	31.0402	30.0743
460054	1.5710	0.8798	26.3939	28.1478	28.0095	27.5230
460055	***	*	*	*	23.0754	23.0754
460056	0.8224	0.8670	*	*	*	*
470001	1.3548	1.0020	32.2887	34.5891	33.5210	33.3794
470003	1.7940	1.0287	30.0535	35.8753	36.7310	34.6762
470005	1.3682	0.9418	33.9969	32.1087	32.9351	33.0049
470011	1.2239	0.9418	30.8742	32.1668	33.3363	32.1514
470012	1.2953	1.0107	29.8259	30.9839	32.7000	31.2194
470024	1.3785	1.0287	27.3106	28.9203	29.2634	28.4912
490001	1.1846	0.8022	24.6883	25.2705	26.8824	25.6319
490002	0.9564	0.8025	24.0672	26.2533	27.6339	26.0225
490004	1.4283	0.9199	28.8660	30.6657	32.4510	30.6797
490005	1.7029	1.0528	31.4909	32.7159	34.9016	33.0655
490007	2.0623	0.8910	30.7411	31.5954	32.4585	31.6038
490009	2.0440	0.9199	31.4260	30.5748	31.9464	31.3125
490011	1.7060	0.8910	28.8780	30.5522	31.9477	30.4112
490012	1.1797	0.8022	21.8322	22.3339	24.4273	22.9668
490013	1.3615	0.9443	27.3486	27.4108	28.5292	27.7687
490017	1.6019	0.8910	29.6784	29.5853	30.9016	30.0800
490018	1.3937	0.9199	27.8682	28.8491	29.5557	28.7702
490019	1.3345	1.0528	29.8891	33.5636	33.7732	32.4051
490020	1.3546	0.9490	30.6013	32.5621	33.3424	32.1187
490021	1.4713	0.8514	28.1254	28.1343	30.1996	28.7959
490022	1.5783	1.0528	31.7985	34.5366	33.3594	33.2678
490023	1.4038	1.0528	32.6308	33.4561	35.6287	33.9517
490024	1.7367	0.8977	29.0407	29.9188	31.4817	30.2055
490027	1.4257	0.8022	24.3834	23.6876	25.1676	24.4417
490032	2.0641	0.9490	28.0120	30.0331	32.8630	30.3730
490033	1.2418	1.0528	30.9910	32.1854	35.3515	32.8345
490037	1.1921	0.8022	26.2951	28.9020	27.7776	27.6367
490038	1.1365	0.8025	24.0852	25.7219	26.6032	25.5603
490040	1.6870	1.0528	35.6822	36.5546	38.2206	36.8577
490041	1.7419	0.8910	29.1244	30.4198	31.6472	30.4410
490042	1.3852	0.8821	26.6078	28.1989	28.6315	27.8249
490043	1.4528	1.0528	36.5982	33.4364	35.4344	35.1234
490044	1.5021	0.8910	24.1763	30.3606	31.1612	28.6713
490045	1.4362	1.0528	32.8774	34.0289	33.2265	33.3809
490046	1.5611	0.8910	29.3882	30.5445	32.0210	30.6570
490048	1.5181	0.8977	28.0320	29.1952	32.3423	29.8090
490050	1.6932	1.0528	31.1370	33.3979	35.3403	33.2725
490052	1.7570	0.8910	25.4179	26.5858	27.5774	26.5230
490053	1.2123	0.8022	24.6206	25.5300	27.6485	26.0136
490057	1.6341	0.8910	29.0700	30.5163	31.4309	30.3569
490059	1.7476	0.9490	32.1031	32.7894	33.7273	32.8891
490060	1.0988	0.8022	25.7765	26.2620	26.8737	26.2877
490063	1.9288	1.0528	34.1179	35.7722	36.5637	35.5131
490066	1.3993	0.9490	31.4298	31.1949	32.7989	31.8222
490067	1.3116	0.9490	26.7802	27.5172	28.6602	27.6312
490069	1.7572	0.9490	30.1482	33.1140	33.7536	32.4091
490071	***	*	33.7118	36.1311	37.5431	35.7423
490073	***	*	46.4210	*	*	46.4210
490075	1.4728	0.8129	27.3424	27.8663	28.5190	27.8778
490077	1.4245	0.9199	31.0016	33.5266	33.9842	32.8749
490079	1.2258	0.8930	24.2066	25.3814	26.8351	25.4595
490084	1.1514	0.8258	26.3234	28.0861	29.1970	27.8957
490088	1.0343	0.8514	26.0285	26.5138	27.3084	26.6193
490089	1.0904	0.8977	27.4587	28.7200	28.6712	28.2991
490090	1.1170	0.8022	27.0760	28.1280	30.1118	28.4477
490092	1.0905	0.8022	27.5277	26.9546	27.9451	27.4776
490093	1.5805	0.8910	28.7122	29.2159	30.8677	29.6183
490094	1.0446	0.9490	29.7990	33.4960	35.2385	32.9148
490097	1.1213	0.8022	27.4608	27.3832	30.3668	28.3804
490098	1.2490	0.8022	26.7152	29.1195	30.2687	28.7591
490101	1.5529	1.0528	32.9516	36.2501	37.1059	35.5123
490104	0.8635	0.9490	19.0056	21.5140	25.4787	21.5644
490105	0.7752	0.8025	*	*	*	*
490106	0.7217	*	26.2318	28.0073	29.6648	27.8955
490107	1.5612	1.0528	35.0272	36.5156	37.8903	36.4937
490108	0.9350	0.8514	27.8717	26.8474	28.1416	27.6250
490109	0.8360	0.8910	21.6711	26.3100	35.3911	26.6233
490110	1.4981	0.8429	26.3089	28.6114	30.4109	28.4393

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)
490111	1.3002	0.8022	26.4297	25.9801	25.5907	26.0172
490112	1.8616	0.9490	31.2549	32.6940	34.4443	32.7837
490113	1.3453	1.0528	34.7841	34.3609	35.6977	34.9643
490114	1.2877	0.8022	23.0533	23.6217	24.3732	23.7167
490115	1.1261	0.8022	23.2118	24.2056	24.5703	24.0070
490116	1.1200	0.8022	25.0351	26.8981	27.6038	26.5237
490117	1.1400	0.8022	20.3038	19.0627	21.2532	20.2016
490118	1.7126	0.9490	31.2407	32.7697	34.4043	32.7684
490119	1.3791	0.8910	29.5222	30.2401	31.7972	30.5977
490120	1.5447	0.8910	27.1990	29.8199	31.3551	29.5060
490122	1.6804	1.0528	35.2234	36.8356	37.2375	36.4494
490123	1.1733	0.8022	24.6011	25.9018	26.5735	25.6900
490126	1.2835	0.8022	25.3294	26.4277	28.1088	26.5952
490127	1.1572	0.8022	23.1399	23.5161	25.8497	24.1610
490130	1.3539	0.8910	25.9782	27.8912	28.5477	27.5050
490134	0.8484	0.8022	31.1495	36.6290	38.4739	35.3411
490135	0.8329	0.8977	27.2795	29.4817	30.6951	29.1241
490136	1.5986	0.9490	31.2911	33.2256	33.6157	32.9121
490137	***	*	*	33.7203	*	33.7203
490138	***	*	*	*	29.6036	29.6036
490140	1.1707	1.0528	*	*	*	*
500001	1.6920	1.1349	37.5323	34.4057	36.7485	36.1853
500002	1.4064	1.0068	30.1872	32.8317	34.4457	32.6043
500003	1.3883	1.1227	32.7983	34.5869	35.4252	34.3645
500005	1.9139	1.1349	36.0918	36.7598	34.3809	35.6939
500007	1.3046	1.1227	31.0313	32.8189	34.5488	32.8239
500008	2.0942	1.1349	34.7810	37.6578	39.2115	37.2326
500011	1.5112	1.1349	38.3979	35.9571	39.3373	37.8799
500012	1.6682	1.0068	33.1685	34.1650	36.8940	34.8609
500014	1.7774	1.1349	37.2698	36.3915	39.1471	37.5939
500015	1.4145	1.1349	40.8683	41.8914	37.7736	39.9782
500016	1.7006	1.1227	34.2828	35.1946	36.9924	35.5231
500019	1.2954	1.0234	33.8882	33.3151	33.7090	33.6359
500021	1.2735	1.1227	33.5610	34.1696	35.4996	34.4427
500024	1.6970	1.1036	37.4529	38.1144	38.4352	38.0007
500025	2.0660	1.1349	44.7105	45.7929	46.4624	45.6964
500026	1.5246	1.1349	35.5080	38.9294	39.8893	38.0789
500027	1.5514	1.1349	42.4974	43.3521	46.0491	43.9688
500030	1.6107	1.1258	36.9489	37.8938	39.4971	38.1930
500031	1.3816	1.0972	34.1651	37.1418	39.3840	37.0128
500033	1.3025	1.0068	32.6753	33.5611	34.6143	33.6548
500036	1.3062	1.0068	31.9164	33.0937	34.4541	33.2416
500037	1.0522	1.0068	29.1773	31.5221	33.5660	31.4586
500039	1.6290	1.1227	34.5739	35.7525	36.9763	35.8174
500041	1.4539	1.1167	36.9273	37.1754	37.2800	37.1469
500044	1.8709	1.0547	32.0743	32.9066	37.2488	34.2335
500049	1.3589	1.0068	30.8135	32.9904	35.3687	33.0660
500050	1.6841	1.1167	35.7254	35.8576	38.7730	36.8283
500051	1.7983	1.1349	36.4764	38.1805	40.4412	38.4137
500052	0.5257	1.1349	*	*	*	*
500053	1.2927	1.0068	28.5664	35.5776	32.3856	32.3854
500054	2.0439	1.0547	34.8114	36.0163	36.9999	35.9956
500058	1.7819	1.0068	32.6843	33.9116	35.3652	34.0076
500060	1.3839	1.1349	40.3040	33.4139	36.1525	36.3210
500064	2.1038	1.1349	34.7925	36.5889	38.6353	36.7049
500072	1.2795	1.0358	33.1148	33.7689	34.6589	33.8656
500077	1.6554	1.0547	34.3114	35.6352	36.5898	35.5608
500079	1.4615	1.1227	34.2420	35.0285	39.6936	36.2947
500084	1.2299	1.1349	33.3072	35.9603	37.4187	35.5883
500088	1.5216	1.1349	38.5194	39.5328	42.2162	40.1736
500108	1.7135	1.1227	35.8918	36.9874	38.4448	37.1553
500119	1.3965	1.0547	31.7125	33.2862	37.1488	34.2958
500124	1.5615	1.1349	36.3338	36.2555	38.4912	37.0793
500129	1.7301	1.1227	37.3189	39.0479	40.9377	39.1488
500134	***	*	28.9759	27.6000	*	28.2473
500139	1.5940	1.1036	37.5709	37.3065	40.1585	38.3025
500141	1.3018	1.1349	34.2384	35.0996	36.5725	35.3401
500143	0.8345	1.1036	26.3893	27.6976	27.0775	27.0512
500148	1.2582	1.0068	24.6347	29.1435	29.3544	27.8015
500150	1.3469	1.1167	34.8480	37.1238	39.5081	37.2747
500151	1.2724	1.1220	*	*	*	*
510001	1.9015	0.8267	26.7924	27.6648	28.5547	27.6980

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)
510002	1.3699	0.8821	24.8846	25.3769	26.9853	25.7385
510006	1.3756	0.8267	26.6421	27.5033	28.3955	27.5157
510007	1.7093	0.8877	28.5783	29.7125	31.3077	29.8638
510008	1.4922	0.9457	27.4709	30.6397	31.5259	29.9303
510012	0.9949	0.7649	22.9038	23.9222	23.9043	23.5701
510013	1.1575	0.7539	22.9612	22.1864	22.8751	22.6681
510018	1.1130	0.8095	23.7736	22.6582	24.2180	23.5308
510022	1.8567	0.8095	27.6119	28.4911	28.9357	28.3539
510023	1.1934	0.7539	23.1461	21.1483	23.2076	22.4628
510024	1.6521	0.8267	31.1327	32.3022	29.9708	31.1317
510026	1.0087	*	17.8275	18.6662	*	18.2486
510029	1.4261	0.8095	25.3925	24.6743	25.6829	25.2477
510030	1.1745	0.7539	25.5600	26.0174	26.6678	26.0881
510031	1.6207	0.8095	26.7872	29.5993	29.3959	28.5743
510033	1.5597	0.7539	24.2839	24.4150	24.9084	24.5138
510038	1.1536	0.7539	21.7545	21.1103	22.4081	21.7738
510039	1.3776	0.7539	21.3819	21.7158	22.0315	21.7109
510046	1.4481	0.8022	24.7187	23.2634	24.7148	24.2372
510047	1.2916	0.8267	28.8794	30.0461	31.1211	30.0444
510048	1.3054	0.7539	23.6396	25.0987	26.5392	25.1347
510050	1.8089	0.8447	23.5794	24.3081	24.5183	24.1217
510053	1.0042	0.7539	22.6288	24.3853	25.2151	24.0904
510055	1.6973	0.8877	30.7382	32.3284	33.3131	32.1762
510058	1.3980	0.7539	24.8770	24.9360	23.8756	24.5556
510059	***	*	21.9053	20.5651	23.5264	22.1121
510062	1.2221	0.8095	27.7971	30.4515	32.4789	30.2757
510067	***	*	25.2248	25.4499	*	25.3238
510070	1.3121	0.8095	25.4981	26.1227	28.1833	26.6078
510071	1.3504	0.7749	23.4553	21.7085	23.4364	22.8851
510072	1.0600	0.7539	20.2387	20.1981	21.4877	20.6330
510077	1.0537	0.8726	27.1611	24.7849	27.0283	26.3357
510082	1.2339	0.7539	21.1665	24.7558	22.7633	22.9272
510085	1.4818	0.8095	26.8133	27.6206	24.4217	26.3568
510086	1.1482	0.7539	20.1965	21.2628	20.3541	20.5838
510090	***	*	39.0787	*	*	39.0787
520002	1.3482	0.9597	28.3413	28.2765	29.3772	28.6949

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)
520004	1.4996	0.9815	30.9212	32.9848	34.1823	32.6640
520008	1.6075	1.0183	33.6774	36.6697	38.2773	36.3293
520009	1.8579	0.9328	29.6290	31.0683	31.6077	30.8042
520011	1.3433	0.9200	29.5024	31.8421	33.2840	31.5924
520013	1.6336	1.0971	32.1721	33.9209	34.9912	33.6871
520017	1.2107	0.9552	31.0537	31.8512	33.6596	32.2021
520019	1.2522	0.9200	30.2189	28.8256	25.1393	27.9899
520021	1.3391	1.0683	29.7809	29.0525	30.3637	29.7448
520027	1.4301	1.0183	33.5836	33.5264	35.8989	34.3661
520028	1.3940	1.1045	29.4694	28.1055	30.4329	29.3782
520030	1.7246	0.9749	31.6807	32.0646	34.2134	32.6060
520033	1.3879	0.9200	30.2631	29.5690	31.1357	30.3355
520034	1.3078	0.9200	28.1819	30.4913	31.6360	30.1594
520035	1.5330	0.9365	29.4076	31.0972	32.7598	31.1073
520037	1.7279	0.9597	32.2206	33.1606	35.6143	33.6874
520038	1.2914	1.0183	30.5267	32.6502	32.9136	32.0864
520040	***	*	35.9652	*	*	35.9652
520041	1.0128	1.1264	26.1586	28.3889	30.2044	28.2342
520044	1.5130	0.9365	28.6620	*	31.9574	30.2713
520045	1.7890	0.9488	30.0856	29.6250	33.3624	30.9435
520048	1.6586	0.9488	30.1483	31.8604	33.1912	31.7302
520049	1.9727	0.9395	29.4238	29.8707	30.8192	30.0306
520051	1.5852	1.0183	32.4131	32.5510	35.4306	33.4280
520057	1.2057	0.9468	29.1597	31.7777	34.0636	31.7443
520059	1.4262	1.0183	31.1798	32.1905	33.6499	32.3654
520062	1.3557	1.0183	32.7015	37.5630	37.0486	35.8633
520063	1.2023	1.0183	31.5200	32.6383	34.1752	32.7552
520064	1.6643	1.0183	33.1269	34.1899	36.0888	34.4290
520066	1.4525	0.9645	31.6793	31.2257	33.6991	32.1980
520070	1.8311	0.9552	30.0475	30.2454	32.1612	30.8199
520071	1.2720	1.0183	31.5452	32.9974	33.3809	32.6879
520075	1.8243	0.9395	32.2773	33.5393	34.0940	33.3072
520076	1.2579	1.0183	26.8943	28.0857	30.1876	28.4156
520078	1.6147	1.0183	32.0200	32.8377	33.6183	32.8325
520083	1.6732	1.1264	34.7230	36.8165	38.3022	36.6698
520087	1.6998	0.9815	31.9771	33.5759	34.5484	33.3836

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)
520088	1.3791	0.9423	30.7482	32.9061	32.7635	32.1564
520089	1.5783	1.1264	34.9357	36.3819	38.0477	36.4960
520091	1.3243	0.9200	28.7180	29.9318	31.2583	29.9694
520095	1.2864	1.1045	33.2426	33.3298	35.6038	34.0564
520096	1.4255	1.0183	29.2895	31.5023	37.8473	32.7143
520097	1.4507	0.9395	30.5442	32.2225	34.3463	32.3367
520098	2.0458	1.1264	38.0993	39.1444	41.0875	39.4904
520100	1.3212	0.9645	31.7772	32.4038	34.0129	32.7394
520102	1.2714	0.9799	31.5756	31.9275	34.1540	32.5754
520103	1.5487	1.0183	34.5640	35.3825	36.9374	35.6373
520107	1.3724	0.9200	30.0354	31.6500	31.1944	30.9712
520109	1.0287	0.9200	25.9740	27.2739	28.4723	27.2704
520113	1.4088	0.9203	33.3040	34.9718	35.6811	34.6390
520116	1.2781	1.0183	31.6702	32.7105	34.6479	33.0174
520136	1.8091	1.0183	32.3504	32.8906	33.7156	32.9944
520138	1.9849	1.0183	32.5677	33.5487	36.0639	34.0671
520139	1.4138	1.0183	31.7086	32.9369	34.1005	32.9701
520160	1.7449	0.9328	30.3052	31.0392	33.4097	31.5457
520170	1.6326	1.0183	31.7610	35.2627	33.8551	33.5743
520177	1.7357	1.0183	33.1243	34.6960	35.5968	34.5395
520189	1.3474	1.0683	29.2229	29.0333	31.6728	29.9933
520193	1.7818	0.9395	29.4737	30.8077	32.6915	31.0661
520194	1.7194	1.0183	31.0015	36.9520	35.9012	34.6574
520195	***	*	41.6120	37.8891	*	39.7179
520196	1.7921	0.9552	33.4890	32.0197	35.9651	33.8008
520198	1.4018	0.9488	29.9803	30.6303	32.9857	31.2343
520199	2.1323	1.0183	37.0128	45.5967	46.6466	43.7273
520202	1.7481	0.9749	*	33.6427	34.1795	33.9129
520203	***	*	*	*	44.8075	44.8075
520204	1.0509	1.0183	*	*	*	*
520205	2.1096	1.0183	*	*	*	*
530002	1.1686	1.0000	29.2418	32.5654	34.0162	32.0416
530006	1.2785	1.0000	30.3724	32.8615	33.0497	32.1244
530008	1.1051	1.0000	30.6010	30.6600	30.9930	30.7509
530009	0.8427	1.0000	27.0555	27.3359	30.2442	28.1939
530010	1.2811	1.0000	28.5534	30.1134	32.0702	30.2636
530011	1.1057	1.0000	31.1329	31.8923	31.4116	31.4710
530012	1.6294	1.0000	30.6109	31.1738	32.9673	31.6224
530014	1.4706	1.0000	29.6724	31.2573	32.7632	31.2175
530015	1.2800	1.0000	33.4903	36.0871	37.1084	35.5271
530017	1.1557	*	25.8183	24.0911	*	24.8262
530025	1.2173	1.0000	28.8963	31.4614	30.9881	30.4565
530032	1.1632	1.0000	25.4267	26.7025	31.0895	27.6738
530033	2.0646	1.0000	*	*	*	*
640001	0.8536	*	*	*	*	*
650001	1.4006	*	*	*	*	*
660001	1.0796	*	*	*	*	*
670002	1.0505	0.9716	29.1376	29.9545	30.5403	29.8855
670003	***	*	33.8986	33.4713	33.2138	33.4909
670004	1.1660	0.7976	25.3706	25.5671	26.9594	25.9384
670005	1.7721	0.9902	31.9464	41.2085	29.7566	33.4891
670006	1.9552	0.9480	27.1064	34.6785	36.8149	32.5821
670007	***	*	*	29.5985	30.3409	30.0101
670008	1.5966	0.9902	*	30.3978	30.7920	30.6232
670009	***	*	*	31.8096	29.0678	30.1558
670010	0.8338	0.9716	*	35.6620	29.6579	31.5918
670011	1.0270	0.9480	*	32.1855	30.2123	30.9712
670012	2.2140	0.9902	*	24.1597	24.2268	24.1922
670013	***	*	*	29.4886	*	29.4886
670014	***	*	*	34.6108	*	34.6108
670015	***	*	*	35.3054	*	35.3054
670016	***	*	*	*	30.9508	30.9508
670017	***	*	*	*	30.4704	30.4704
670018	0.9687	0.9902	*	*	34.7894	34.7894
670019	1.5202	0.9902	*	*	42.1560	42.1560
670020	***	*	*	*	39.6117	39.6117
670022	***	*	*	32.9889	34.0531	33.5210
670023	1.4036	0.9384	*	*	32.5127	32.5127
670024	1.6178	0.9902	*	*	30.0126	30.0126
670025	3.0845	0.9716	*	*	39.9514	39.9514
670026	***	*	*	*	21.8657	21.8657
670027	1.9240	0.9902	*	*	19.3426	19.3426

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)
670028	***	*	*	*	43.3999	43.3999
670029	1.7447	0.9902	*	*	24.7406	24.7406
670030	***	*	*	*	32.0240	32.0240
670031	1.3908	0.9902	*	*	32.9088	32.9088
670033	1.1449	0.9716	*	*	*	*
670034	1.4385	0.9480	*	*	31.7740	31.7740
670040	0.8256	0.9902	*	*	20.5100	20.5100
670041	1.5612	0.9480	*	*	*	*
670042	1.7645	0.9384	*	*	*	*
670043	1.2712	0.9480	*	*	*	*
670044	1.2345	0.9716	*	*	*	*
670046	1.2291	0.9384	*	*	*	*
670047	1.4178	0.8555	*	*	*	*
670048	1.2701	0.9902	*	*	*	*
670049	1.4828	0.9716	*	*	*	*
670050	1.2258	0.8899	*	*	*	*
670051	1.7132	0.9202	*	*	*	*
670052	0.9734	0.9384	*	*	*	*
670053	1.5075	0.9902	*	*	*	*
670054	2.1510	0.9030	*	*	*	*
670055	1.4073	0.9030	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.D.3.of this final 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	29.3909	28.1763
10380	Aguadilla-Isabela-San Sebastián, PR	11.8144	11.2850
10420	Akron, OH	30.9362	29.7258
10500	Albany, GA	31.7580	30.0112
10580	Albany-Schenectady-Troy, NY	30.3974	29.4952
10740	Albuquerque, NM	33.7050	32.1496
10780	Alexandria, LA	28.4788	27.3669
10900	Allentown-Bethlehem-Easton, PA-NJ	32.8737	32.3593
11020	Altoona, PA	30.0597	28.7831
11100	Amarillo, TX	29.9435	29.2807
11180	Ames, IA	35.0814	32.5822
11260	Anchorage, AK	41.3104	39.7608
11300	Anderson, IN	32.4212	30.5936
11340	[1]Anderson, SC	30.8169	30.9551
11460	Ann Arbor, MI	35.2845	34.4765
11500	Anniston-Oxford, AL	27.5934	26.3193
11540	Appleton, WI	32.6318	31.2410
11700	Asheville, NC	31.6120	30.6084
12020	Athens-Clarke County, GA	33.0748	31.1812
12060	Atlanta-Sandy Springs-Marietta, GA	33.4077	32.3782
12100	Atlantic City-Hammonton, NJ	38.4997	38.3776
12220	Auburn-Opelika, AL	26.0907	26.1631
12260	Augusta-Richmond County, GA-SC	33.5162	32.0883
12420	Austin-Round Rock-San Marcos, TX	33.2589	31.9944
12540	Bakersfield-Delano, CA	41.5152	38.7958
12580	Baltimore-Towson, MD	35.6196	33.9828
12620	Bangor, ME	33.8011	33.3690
12700	Barnstable Town, MA	44.7717	42.6487
12940	Baton Rouge, LA	30.4918	28.2187
12980	Battle Creek, MI	34.0685	33.4402

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
13020	Bay City, MI	32.9136	31.6771
13140	Beaumont-Port Arthur, TX	29.5338	28.3877
13380	Bellingham, WA	39.4971	38.1930
13460	Bend, OR	39.2532	37.6943
13644	Bethesda-Rockville-Frederick, MD	36.3564	34.8317
13740	Billings, MT	31.2253	30.2493
13780	Binghamton, NY	31.1820	29.8246
13820	Birmingham-Hoover, AL	30.1283	29.0233
13900	Bismarck, ND	26.6724	25.4937
13980	Blacksburg-Christiansburg-Radford, VA	28.9571	27.7344
14020	Bloomington, IN	32.4195	31.4102
14060	Bloomington-Normal, IL	33.3969	31.9463
14260	Boise City-Nampa, ID	32.4819	31.3456
14484	Boston-Quincy, MA	43.0219	41.0286
14500	Boulder, CO	35.3187	34.0835
14540	Bowling Green, KY	30.4527	28.6487
14740	Bremerton-Silverdale, WA	36.9763	35.8174
14860	Bridgeport-Stamford-Norwalk, CT	44.1247	43.0317
15180	Brownsville-Harlingen, TX	33.1270	31.3902
15260	Brunswick, GA	32.4931	31.8044
15380	Buffalo-Niagara Falls, NY	33.6085	32.5052
15500	Burlington, NC	30.6771	29.1880
15540	Burlington-South Burlington, VT	36.0939	34.0261
15764	Cambridge-Newton-Framingham, MA	39.4262	37.7787
15804	Camden, NJ	36.2611	34.9769
15940	Canton-Massillon, OH	30.1106	29.2647
15980	Cape Coral-Fort Myers, FL	32.1166	31.0844
16020	Cape Girardeau-Jackson, MO-IL	31.0770	30.3007
16180	Carson City, NV	35.8937	34.3305
16220	Casper, WY	32.9673	31.6224
16300	Cedar Rapids, IA	30.7306	29.6890
16580	Champaign-Urbana, IL	35.4707	33.2048
16620	Charleston, WV	28.2152	27.7486
16700	Charleston-North Charleston-Summerville, SC	32.5295	31.1240
16740	Charlotte-Gastonia-Rock Hill, NC-SC	32.4650	31.5639
16820	Charlottesville, VA	32.2746	31.5677
16860	Chattanooga, TN-GA	31.0061	29.8050
16940	Cheyenne, WY	32.7632	31.2175
16974	Chicago-Joliet-Naperville, IL	36.7976	34.9748
17020	Chico, CA	39.6319	37.1974
17140	Cincinnati-Middletown, OH-KY-IN	33.6410	32.0489
17300	Clarksville, TN-KY	27.4249	26.9273
17420	Cleveland, TN	27.2095	26.1996
17460	Cleveland-Elyria-Mentor, OH	31.7574	30.5814
17660	Coeur d'Alene, ID	32.1727	30.7782
17780	College Station-Bryan, TX	32.2837	30.8924
17820	Colorado Springs, CO	32.2482	31.9285
17860	Columbia, MO	28.8393	28.3095
17900	Columbia, SC	30.8096	29.8689
17980	Columbus, GA-AL	31.8325	30.1927
18020	Columbus, IN	33.0802	32.3311
18140	Columbus, OH	35.5285	33.8221
18580	Corpus Christi, TX	29.9509	28.8133
18700	Corvallis, OR	36.1082	36.0941
18880	[2]Crestview-Fort Walton Beach-Destin, FL	30.6336	29.2670
19060	Cumberland, MD-WV	28.7612	26.6865
19124	Dallas-Plano-Irving, TX	34.0898	32.8669
19140	Dalton, GA	29.7045	28.6612
19180	Danville, IL	33.9389	31.5436
19260	Danville, VA	28.5190	27.8778
19340	Davenport-Moline-Rock Island, IA-IL	29.4262	28.1392
19380	Dayton, OH	32.0602	31.0420
19460	Decatur, AL	26.3298	25.6694
19500	Decatur, IL	27.8397	27.0891
19660	Deltona-Daytona Beach-Ormond Beach, FL	30.6663	29.6796
19740	Denver-Aurora-Broomfield, CO	37.0905	35.6538
19780	Des Moines-West Des Moines, IA	33.2650	31.9737
19804	Detroit-Livonia-Dearborn, MI	34.1304	33.1146
20020	Dothan, AL	26.3633	25.5325
20100	Dover, DE	35.0227	34.3410

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
20220	Dubuque, IA	29.9041	28.4331
20260	Duluth, MN-WI	37.6920	35.8163
20500	Durham-Chapel Hill, NC	33.7336	32.4379
20740	Eau Claire, WI	33.5120	32.1505
20764	Edison-New Brunswick, NJ	38.0910	36.9900
20940	El Centro, CA	32.5151	30.4045
21060	Elizabethtown, KY	29.2398	28.1367
21140	Elkhart-Goshen, IN	32.9671	31.8117
21300	Elmira, NY	29.8128	28.3056
21340	El Paso, TX	30.0135	29.1988
21500	Erie, PA	29.1833	28.9337
21660	Eugene-Springfield, OR	39.5656	37.5129
21780	Evansville, IN-KY	29.3050	28.4385
21820	Fairbanks, AK	38.4856	37.2454
21940	Fajardo, PR	13.5864	13.1629
22020	Fargo, ND-MN	28.3794	27.3949
22140	Farmington, NM	32.6752	27.9187
22180	Fayetteville, NC	33.0033	32.2689
22220	Fayetteville-Springdale-Rogers, AR-MO	30.1880	29.7236
22380	Flagstaff, AZ	43.4849	40.9819
22420	Flint, MI	39.7323	37.7690
22500	Florence, SC	29.6011	28.2560
22520	Florence-Muscle Shoals, AL	28.2551	26.6988
22540	Fond du Lac, WI	32.7635	32.1564
22660	Fort Collins-Loveland, CO	33.2140	32.4354
22744	Fort Lauderdale-Pompano Beach-Deerfield	34.9169	33.6030
22900	Fort Smith, AR-OK	27.0611	26.4018
23060	Fort Wayne, IN	32.4446	30.4302
23104	Fort Worth-Arlington, TX	32.9229	31.9783
23420	Fresno, CA	39.9089	37.8309
23460	Gadsden, AL	25.3778	26.3382
23540	Gainesville, FL	32.8819	31.4418
23580	Gainesville, GA	33.3589	31.6865
23844	Gary, IN	31.8856	30.9020
24020	Glens Falls, NY	30.8188	29.5351
24140	Goldsboro, NC	32.4003	31.0261
24220	Grand Forks, ND-MN	28.0464	26.7617
24300	Grand Junction, CO	34.4707	32.8218
24340	Grand Rapids-Wyoming, MI	32.5226	31.2450
24500	Great Falls, MT	28.8574	28.2306
24540	Greeley, CO	33.5969	32.8587
24580	Green Bay, WI	32.9628	31.7766
24660	Greensboro-High Point, NC	31.4082	30.5520
24780	Greenville, NC	32.6194	31.4417
24860	Greenville-Mauldin-Easley, SC	32.9929	32.4189
25020	Guayama, PR	12.4872	11.4523
25060	Gulfport-Biloxi, MS	30.8067	29.6360
25180	Hagerstown-Martinsburg, MD-WV	33.1812	31.3121
25260	Hanford-Corcoran, CA	40.0199	37.9871
25420	Harrisburg-Carlisle, PA	32.1188	30.8057
25500	Harrisonburg, VA	32.4510	30.6797
25540	Hartford-West Hartford-East Hartford, C	38.8366	37.6933
25620	Hattiesburg, MS	27.7518	26.1793
25860	Hickory-Lenoir-Morganton, NC	30.2000	29.6942
25980	[1]Hinesville-Fort Stewart, GA	----	----
26100	Holland-Grand Haven, MI	30.7055	29.9201
26180	Honolulu, HI	40.7002	38.8806
26300	Hot Springs, AR	32.4498	30.8410
26380	Houma-Bayou Cane-Thibodaux, LA	27.9660	26.7720
26420	Houston-Sugar Land-Baytown, TX	34.7377	33.3888
26580	Huntington-Ashland, WV-KY-OH	31.1439	30.3273
26620	Huntsville, AL	31.6885	30.2437
26820	Idaho Falls, ID	33.7774	31.5648
26900	Indianapolis-Carmel, IN	33.3578	32.4481
26980	Iowa City, IA	33.3532	31.7664
27060	Ithaca, NY	34.1319	32.8681
27100	Jackson, MI	32.3277	30.8017
27140	Jackson, MS	28.1832	27.2339
27180	Jackson, TN	29.2500	28.4231

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
27260	Jacksonville, FL	31.1257	30.3725
27340	Jacksonville, NC	27.4623	27.2060
27500	Janesville, WI	33.8404	32.4421
27620	Jefferson City, MO	30.0394	29.6659
27740	Johnson City, TN	27.7847	26.3565
27780	Johnstown, PA	29.1315	27.8663
27860	Jonesboro, AR	27.3445	26.4967
27900	Joplin, MO	29.4604	29.6822
28020	Kalamazoo-Portage, MI	36.0003	35.2087
28100	Kankakee-Bradley, IL	36.9010	34.8193
28140	Kansas City, MO-KS	33.3654	31.9781
28420	Kennewick-Pasco-Richland, WA	34.3201	33.4568
28660	Killeen-Temple-Fort Hood, TX	30.9891	29.7200
28700	Kingsport-Bristol-Bristol, TN-VA	26.8107	26.4561
28740	Kingston, NY	31.9474	31.3224
28940	Knoxville, TN	27.4076	26.4261
29020	Kokomo, IN	31.4887	31.3139
29100	La Crosse, WI-MN	34.4353	33.1577
29140	Lafayette, IN	32.3014	30.6080
29180	Lafayette, LA	29.8981	28.6571
29340	Lake Charles, LA	28.6541	26.6140
29404	Lake County-Kenosha County, IL-WI	37.4802	35.3290
29420	Lake Havasu City-Kingman, AZ	35.9090	34.5400
29460	Lakeland-Winter Haven, FL	30.1646	29.0309
29540	Lancaster, PA	34.1754	32.6039
29620	Lansing-East Lansing, MI	35.8490	33.4929
29700	Laredo, TX	28.7393	28.4260
29740	Las Cruces, NM	31.8955	29.9170
29820	Las Vegas-Paradise, NV	41.2307	39.5637
29940	Lawrence, KS	29.7194	28.4166
30020	Lawton, OK	30.0825	28.4140
30140	Lebanon, PA	28.4513	28.6007
30300	Lewiston, ID-WA	32.0470	31.1256
30340	Lewiston-Auburn, ME	31.2634	30.6878
30460	Lexington-Fayette, KY	30.6315	29.7761
30620	Lima, OH	32.3554	31.2520
30700	Lincoln, NE	33.1279	31.8966
30780	Little Rock-N.Little Rock-Conway,AR	30.3480	29.3073
30860	Logan, UT-ID	30.8690	29.8643
30980	Longview, TX	29.9954	27.9338
31020	Longview, WA	37.2800	37.1469
31084	Los Angeles-Long Beach-Santa Ana, CA	42.1501	40.4534
31140	Louisville-Jefferson County, KY-IN	30.9349	30.2112
31180	Lubbock, TX	31.2222	29.6486
31340	Lynchburg, VA	29.8715	28.5889
31420	Macon, GA	33.2723	33.0316
31460	Madera-Chowchilla, CA	30.1066	28.6043
31540	Madison, WI	39.5188	37.8741
31700	Manchester-Nashua, NH	34.5899	33.9811
31740	Manhattan, KS	27.6606	26.5946
31860	Mankato-North Mankato, MN	32.3603	31.4345
31900	Mansfield, OH	30.7809	30.3006
32420	Mayagüez, PR	12.6106	12.4903
32580	McAllen-Edinburg-Mission, TX	31.0409	30.1041
32780	Medford, OR	35.0068	33.9114
32820	Memphis, TN-MS-AR	32.4302	31.2125
32900	Merced, CA	42.4903	40.5875
33124	Miami-Fort Lauderdale-Pompano Beach, FL	35.7396	33.7671
33140	Michigan City-La Porte, IN	32.8100	30.9505
33260	Midland, TX	33.3018	31.8583
33340	Milwaukee-Waukesha-West Allis, WI	35.6917	34.2341
33460	Minneapolis-St. Paul-Bloomington, MN-WI	38.4912	36.9207
33540	Missoula, MT	30.7633	29.8209
33660	Mobile, AL	27.6784	26.3420
33700	Modesto, CA	42.0463	41.0041
33740	Monroe, LA	28.6395	26.9209
33780	Monroe, MI	31.3285	30.3928
33860	Montgomery, AL	30.0981	28.5142
34060	Morgantown, WV	28.8992	28.5474

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
34100	Morristown, TN	24.8496	24.2674
34580	Mount Vernon-Anacortes, WA	35.1658	33.8790
34620	Muncie, IN	28.6116	27.7641
34740	Muskegon-Norton Shores, MI	34.3815	33.4605
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	30.3990	29.2155
34900	Napa, CA	50.6115	48.0426
34940	Naples-Marco Island, FL	34.2945	32.9966
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	32.8300	31.8685
35004	Nassau-Suffolk, NY	43.9576	42.5763
35084	Newark-Union, NJ-PA	39.6169	38.2397
35300	New Haven-Milford, CT	40.3545	39.1436
35380	New Orleans-Metairie-Kenner, LA	31.4353	30.2034
35644	New York-White Plains-Wayne, NY-NJ	46.0352	44.1205
35660	Niles-Benton Harbor, MI	31.3837	30.3126
35840	[2]North Port-Bradenton-Sarasota, FL	32.3961	31.9398
35980	Norwich-New London, CT	39.8390	38.5751
36084	Oakland-Fremont-Hayward, CA	55.6142	53.3187
36100	Ocala, FL	29.9899	28.8373
36140	Ocean City, NJ	38.0642	36.5086
36220	Odessa, TX	32.9178	32.1325
36260	Ogden-Clearfield, UT	32.6179	31.3719
36420	Oklahoma City, OK	31.0744	29.6772
36500	Olympia, WA	38.2585	37.6047
36540	Omaha-Council Bluffs, NE-IA	33.3534	31.9222
36740	Orlando-Kissimmee-Sanford, FL	32.1529	30.6773
36780	Oshkosh-Neenah, WI	33.2128	31.2405
36980	Owensboro, KY	29.7899	28.8742
37100	Oxnard-Thousand Oaks-Ventura, CA	43.2178	40.5755
37340	Palm Bay-Melbourne-Titusville, FL	32.6258	31.2765
37380	Palm Coast, FL	28.6451	29.3957
37460	Panama City-Lynn Haven-Panama City Beach, FL	28.4458	28.1706
37620	Parkersburg-Marietta-Vienna, WV-OH	25.9451	25.8723
37700	Pascagoula, MS	28.5606	27.4160
37764	Peabody, MA	38.4721	36.5622
37860	Pensacola-Ferry Pass-Brent, FL	28.4525	27.3697
37900	Peoria, IL	32.4282	31.0315
37964	Philadelphia, PA	37.7293	36.3928
38060	Phoenix-Mesa-Glendale, AZ	36.7080	35.0949
38220	Pine Bluff, AR	28.7092	26.7525
38300	Pittsburgh, PA	30.0466	28.9341
38340	Pittsfield, MA	36.5940	35.4680
38540	Pocatello, ID	32.7403	30.8796
38660	Ponce, PR	14.9806	14.1321
38860	Portland-South Portland-Biddeford, ME	34.7002	33.6686
38900	Portland-Vancouver-Hillsboro, OR-WA	39.1814	37.7053
38940	Port St. Lucie, FL	37.6264	34.3677
39100	Poughkeepsie-Newburgh-Middletown, NY	39.9395	37.7330
39140	Prescott, AZ	43.0013	36.4202
39300	Providence-New Bedford-Fall River, RI-M	37.5318	36.1109
39340	Provo-Orem, UT	32.2876	31.4238
39380	Pueblo, CO	30.0061	28.7433
39460	Punta Gorda, FL	31.7090	30.7452
39540	Racine, WI	37.1842	32.6643
39580	Raleigh-Cary, NC	33.9095	32.4226
39660	Rapid City, SD	38.3618	34.5081
39740	Reading, PA	31.0132	30.6980
39820	Redding, CA	47.5445	44.9446
39900	Reno-Sparks, NV	36.4432	34.9197
40060	Richmond, VA	33.2943	31.4917
40140	Riverside-San Bernardino-Ontario, CA	40.0305	38.0295
40220	Roanoke, VA	31.4945	29.9852
40340	Rochester, MN	37.5573	36.5714
40380	Rochester, NY	30.4001	29.5878
40420	Rockford, IL	35.0919	33.6893
40484	Rockingham County, NH	35.0453	33.6785
40580	Rocky Mount, NC	31.8519	30.3478
40660	Rome, GA	29.9908	30.3030
40900	Sacramento--Arden-Arcade--Roseville, CA	47.7217	45.3696
40980	Saginaw-Saginaw Township North, MI	32.1512	31.1504
41060	St. Cloud, MN	40.6807	39.1252

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
41100	St. George, UT	32.5036	31.3082
41140	St. Joseph, MO-KS	36.2241	34.8332
41180	St. Louis, MO-IL	31.6252	30.3425
41420	Salem, OR	38.8269	36.7520
41500	Salinas, CA	55.5052	51.7880
41540	Salisbury, MD	31.1911	30.3633
41620	Salt Lake City, UT	32.6832	31.4855
41660	San Angelo, TX	29.6114	28.0547
41700	San Antonio-New Braunfels, TX	31.6787	30.2014
41740	San Diego-Carlsbad-San Marcos, CA	41.0078	38.6905
41780	Sandusky, OH	30.0976	29.3789
41884	San Francisco-San Mateo-Redwood City, CA	53.8614	51.6877
41900	San Germán-Cabo Rojo, PR	15.9545	15.6643
41940	San Jose-Sunnyvale-Santa Clara, CA	57.4086	54.3173
41980	San Juan-Caguas-Guaynabo, PR	15.0173	14.6353
42020	San Luis Obispo-Paso Robles, CA	43.4045	40.8212
42044	Santa Ana-Anaheim-Irvine, CA	41.9387	39.8910
42060	Santa Barbara-Santa Maria-Goleta, CA	41.0198	39.7344
42100	Santa Cruz-Watsonville, CA	56.9503	54.4331
42140	Santa Fe, NM	37.6585	35.8738
42220	Santa Rosa-Petaluma, CA	55.3095	52.3192
42340	Savannah, GA	30.9325	29.9704
42540	Scranton--Wilkes-Barre, PA	28.7256	27.7852
42644	Seattle-Bellevue-Everett, WA	39.8147	38.4950
42680	Sebastian-Vero Beach, FL	32.4285	31.7779
43100	Sheboygan, WI	32.4634	30.8677
43300	Sherman-Denison, TX	29.4876	28.9876
43340	Shreveport-Bossier City, LA	30.1989	28.7455
43580	Sioux City, IA-NE-SD	31.3081	29.8802
43620	Sioux Falls, SD	32.7709	31.1866
43780	South Bend-Mishawaka, IN-MI	34.5202	32.8063
43900	Spartanburg, SC	32.1610	30.6789
44060	Spokane, WA	37.0037	35.4214
44100	Springfield, IL	31.2353	30.6690
44140	Springfield, MA	36.2841	35.1703
44180	Springfield, MO	29.7693	28.7493
44220	Springfield, OH	31.4512	29.8052
44300	State College, PA	30.2608	29.6035
44600	[2]Steubenville-Weirton, OH-WV	25.4371	25.3399
44700	Stockton, CA	44.1493	41.4432
44940	Sumter, SC	28.5547	28.2042
45060	Syracuse, NY	34.9177	33.2806
45104	Tacoma, WA	39.3643	37.5698
45220	Tallahassee, FL	31.4002	29.7435
45300	Tampa-St. Petersburg-Clearwater, FL	31.7936	30.3369
45460	Terre Haute, IN	32.3031	30.7555
45500	Texarkana, TX-Texarkana, AR	27.2696	27.0109
45780	Toledo, OH	32.7682	31.4770
45820	Topeka, KS	31.8997	30.4668
45940	Trenton-Ewing, NJ	35.1767	34.8797
46060	Tucson, AZ	33.8329	32.2966
46140	Tulsa, OK	31.1031	29.4674
46220	Tuscaloosa, AL	31.7928	30.0786
46340	Tyler, TX	28.7056	28.5911
46540	Utica-Rome, NY	30.4859	29.2700
46660	Valdosta, GA	28.4454	27.4066
46700	Vallejo-Fairfield, CA	50.8931	48.5429
47020	Victoria, TX	28.0750	26.7193
47220	Vineland-Millville-Bridgeton, NJ	38.5311	36.5407
47260	Virginia Beach-Norfolk-Newport News, VA	31.2616	29.9710
47300	Visalia-Porterville, CA	38.0028	35.3622
47380	Waco, TX	30.2033	29.0714
47580	Warner Robins, GA	29.5570	30.3218
47644	Warren-Troy-Farmington-Hills, MI	33.9533	33.0854
47894	Washington-Arlington-Alexandria DC-VA	36.9337	35.7943
47940	Waterloo-Cedar Falls, IA	29.6501	28.7760
48140	Wausau, WI	34.2057	32.8089
48300	Wenatchee-East Wenatchee, WA	33.8197	32.3773
48424	West Palm Beach-Boca Raton-Boynton FL	34.3519	32.7303
48540	Wheeling, WV-OH	23.4722	23.0890

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
48620	Wichita, KS	30.9274	30.0098
48660	Wichita Falls, TX	34.6743	32.0379
48700	Williamsport, PA	25.4003	25.8945
48864	Wilmington, DE-MD-NJ	37.6213	35.9753
48900	Wilmington, NC	32.5500	30.7170
49020	Winchester, VA-WV	34.9016	33.0655
49180	Winston-Salem, NC	31.3299	30.1806
49340	Worcester, MA	39.1310	37.4395
49420	Yakima, WA	35.0623	33.5416
49500	Yauco, PR	12.3738	11.4462
49620	York-Hanover, PA	35.0043	32.5132
49660	Youngstown-Warren-Boardman, OH-PA	30.1611	29.3603
49700	Yuba City, CA	37.6462	36.6540
49740	Yuma, AZ	33.0068	32.0520

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.
[2] This is a new CBSA for FY 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	26.0893	25.1777
02	Alaska	44.1109	40.4751
03	Arizona	31.8871	29.9962
04	Arkansas	25.9651	25.2909
05	California	41.6465	40.1229
06	Colorado	33.8948	32.2206
07	Connecticut	39.5041	37.7465
08	Delaware	34.4584	33.5616
10	Florida	29.5695	28.7947
11	Georgia	27.1777	26.2438
12	Hawaii	39.7953	37.9805
13	Idaho	26.1403	25.4389
14	Illinois	29.2532	28.1401
15	Indiana	29.3225	28.4343
16	Iowa	29.7145	28.8979
17	Kansas	27.8637	27.0300
18	Kentucky	27.7424	26.5394
19	Louisiana	27.7685	26.2774
20	Maine	29.9850	28.8603
21	Maryland	32.4809	30.6726
22	Massachusetts[1]	----	----
23	Michigan	30.0378	29.4050
24	Minnesota	31.6218	30.5365
25	Mississippi	26.9628	25.8665
26	Missouri	27.3283	26.6420
27	Montana	29.4632	28.4041
28	Nebraska	31.0365	29.3871
29	Nevada	32.7781	32.3504
30	New Hampshire	35.8411	34.2873
31	New Jersey[2]	----	----
32	New Mexico	31.4455	30.0973
33	New York	29.0487	27.9449
34	North Carolina	29.4993	28.7366
35	North Dakota	24.4993	24.8113
36	Ohio	30.0270	28.8008
37	Oklahoma	28.0619	26.6726
38	Oregon	34.9738	34.1379
39	Pennsylvania	29.8543	28.3010
40	Puerto Rico[2]	----	----
41	Rhode Island[2]	----	----
42	South Carolina	29.4469	28.4812
43	South Dakota	29.3687	28.1972
44	Tennessee	27.9379	26.7067
45	Texas	27.9836	26.9735
46	Utah	30.4186	28.6145
47	Vermont	33.0161	32.4241
49	Virginia	28.1450	27.0788
50	Washington	35.3224	34.0240
51	West Virginia	26.4489	25.4006
52	Wisconsin	32.2771	31.2610
53	Wyoming	32.7881	31.3468

[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.— 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 National Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State	Wage Index	GAF
10180	Abilene, TX	TX	0.8377	0.8858
10380	Aguadilla-Isabela-San Sebastián, PR	PR	0.3368	0.4746
10420	Akron, OH	OH	0.8817	0.9174
10500	Albany, GA	GA	0.9051	0.9340
10580	Albany-Schenectady-Troy, NY	NY	0.8664	0.9065
10740	Albuquerque, NM	NM	0.9607	0.9729
10780	Alexandria, LA	LA	0.8137	0.8683
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1246	1.0837
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9370	0.9564
11020	Altoona, PA	PA	0.8568	0.8996
11100	Amarillo, TX	TX	0.8534	0.8971
11180	Ames, IA	IA	0.9999	0.9999
11260	Anchorage, AK	AK	1.2573	1.1698
11300	Anderson, IN	IN	0.9241	0.9474
11340	Anderson, SC	SC	0.8783	0.9150
11460	Ann Arbor, MI	MI	1.0057	1.0039
11500	Anniston-Oxford, AL	AL	0.7864	0.8483
11540	Appleton, WI	WI	0.9301	0.9516
11700	Asheville, NC	NC	0.9011	0.9312
12020	Athens-Clarke County, GA	GA	0.9427	0.9604
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9522	0.9670
12100	Atlantic City-Hammonton, NJ	NJ	1.1246	1.0837
12220	Auburn-Opelika, AL	AL	0.7437	0.8165
12260	Augusta-Richmond County, GA-SC	GA	0.9553	0.9692
12260	Augusta-Richmond County, GA-SC	SC	0.9553	0.9692
12420	Austin-Round Rock-San Marcos, TX	TX	0.9480	0.9641
12540	Bakersfield-Delano, CA	CA	1.1870	1.1246
12580	Baltimore-Towson, MD	MD	1.0153	1.0105
12620	Bangor, ME	ME	0.9646	0.9756
12700	Barnstable Town, MA	MA	1.2761	1.1817
12940	Baton Rouge, LA	LA	0.8691	0.9084
12980	Battle Creek, MI	MI	0.9710	0.9800
13020	Bay City, MI	MI	0.9381	0.9572
13140	Beaumont-Port Arthur, TX	TX	0.8418	0.8888
13380	Bellingham, WA	WA	1.1258	1.0845
13460	Bend, OR	OR	1.1188	1.0799
13644	Bethesda-Rockville-Frederick, MD	MD	1.0363	1.0247
13740	Billings, MT	MT	1.0000	1.0000
13780	Binghamton, NY	NY	0.8888	0.9224
13820	Birmingham-Hoover, AL	AL	0.8587	0.9009
13900	Bismarck, ND	ND	1.0000	1.0000
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8253	0.8768
14020	Bloomington, IN	IN	0.9241	0.9474
14060	Bloomington-Normal, IL	IL	0.9519	0.9668
14260	Boise City-Nampa, ID	ID	0.9258	0.9486
14484	Boston-Quincy, MA	MA	1.2263	1.1499
14500	Boulder, CO	CO	1.0067	1.0046
14540	Bowling Green, KY	KY	0.8680	0.9076
14740	Bremerton-Silverdale, WA	WA	1.0539	1.0366
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2577	1.1700
15180	Brownsville-Harlingen, TX	TX	0.9442	0.9614
15260	Brunswick, GA	GA	0.9304	0.9518
15380	Buffalo-Niagara Falls, NY	NY	0.9580	0.9710
15500	Burlington, NC	NC	0.8744	0.9122
15540	Burlington-South Burlington, VT	VT	1.0287	1.0196
15764	Cambridge-Newton-Framingham, MA	MA	1.1237	1.0831
15804	Camden, NJ	NJ	1.1246	1.0837
15940	Canton-Massillon, OH	OH	0.8582	0.9006
15980	Cape Coral-Fort Myers, FL	FL	0.9154	0.9413
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8858	0.9203
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8858	0.9203
16180	Carson City, NV	NV	1.0231	1.0158
16220	Casper, WY	WY	1.0000	1.0000
16300	Cedar Rapids, IA	IA	0.8759	0.9133
16580	Champaign-Urbana, IL	IL	1.0110	1.0075
16620	Charleston, WV	WV	0.8095	0.8653
16700	Charleston-North Charleston-Summerville, SC	SC	0.9272	0.9496
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9254	0.9483
16740	Charlotte-Gastonia-Rock Hill, NC-SC	SC	0.9254	0.9483
16820	Charlottesville, VA	VA	0.9199	0.9444
16860	Chattanooga, TN-GA	GA	0.8837	0.9188
16860	Chattanooga, TN-GA	TN	0.8837	0.9188
16940	Cheyenne, WY	WY	1.0000	1.0000
16974	Chicago-Joliet-Naperville, IL	IL	1.0489	1.0332
17020	Chico, CA	CA	1.1870	1.1246
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9589	0.9717
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9589	0.9717
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9589	0.9717
17300	Clarksville, TN-KY	KY	0.7968	0.8559
17300	Clarksville, TN-KY	TN	0.7963	0.8556
17420	Cleveland, TN	TN	0.7963	0.8556
17460	Cleveland-Elyria-Mentor, OH	OH	0.9051	0.9340

CBSA Code	Urban Area	State	Wage Index	GAF
17660	Coeur d'Alene, ID	ID	0.9170	0.9424
17780	College Station-Bryan, TX	TX	0.9202	0.9446
17820	Colorado Springs, CO	CO	0.9661	0.9767
17860	Columbia, MO	MO	0.8227	0.8749
17900	Columbia, SC	SC	0.8781	0.9148
17980	Columbus, GA-AL	AL	0.9073	0.9356
17980	Columbus, GA-AL	GA	0.9073	0.9356
18020	Columbus, IN	IN	0.9429	0.9605
18140	Columbus, OH	OH	1.0127	1.0087
18580	Corpus Christi, TX	TX	0.8537	0.8973
18700	Corvallis, OR	OR	1.0292	1.0199
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8732	0.9113
19060	Cumberland, MD-WV	MD	0.9258	0.9486
19060	Cumberland, MD-WV	WV	0.8197	0.8727
19124	Dallas-Plano-Irving, TX	TX	0.9716	0.9805
19140	Dalton, GA	GA	0.8466	0.8922
19180	Danville, IL	IL	0.9673	0.9775
19260	Danville, VA	VA	0.8129	0.8677
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8615	0.9029
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8615	0.9029
19380	Dayton, OH	OH	0.9138	0.9401
19460	Decatur, AL	AL	0.7505	0.8216
19500	Decatur, IL	IL	0.8338	0.8830
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8741	0.9120
19740	Denver-Aurora-Broomfield, CO	CO	1.0571	1.0388
19780	Des Moines-West Des Moines, IA	IA	0.9481	0.9642
19804	Detroit-Livonia-Dearborn, MI	MI	0.9738	0.9820
20020	Dothan, AL	AL	0.7515	0.8223
20100	Dover, DE	DE	1.0040	1.0027
20220	Dubuque, IA	IA	0.8523	0.8963
20260	Duluth, MN-WI	MN	1.0743	1.0503
20260	Duluth, MN-WI	WI	1.0743	1.0503
20500	Durham-Chapel Hill, NC	NC	0.9615	0.9735
20740	Eau Claire, WI	WI	0.9552	0.9691
20764	Edison-New Brunswick, NJ	NJ	1.1246	1.0837
20940	El Centro, CA	CA	1.1870	1.1246
21060	Elizabethtown, KY	KY	0.8334	0.8827
21140	Elkhart-Goshen, IN	IN	0.9409	0.9591
21300	Elmira, NY	NY	0.8497	0.8945
21340	El Paso, TX	TX	0.8555	0.8986
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.1277	1.0858
21780	Evansville, IN-KY	IN	0.8358	0.8844
21780	Evansville, IN-KY	KY	0.8353	0.8841
21820	Fairbanks, AK	AK	1.2573	1.1698
21940	Fajardo, PR	PR	0.3873	0.5223
22020	Fargo, ND-MN	MN	0.9100	0.9375
22020	Fargo, ND-MN	ND	1.0000	1.0000
22140	Farmington, NM	NM	0.9314	0.9525
22180	Fayetteville, NC	NC	0.9407	0.9590
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8604	0.9022
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.8604	0.9022
22380	Flagstaff, AZ	AZ	1.2394	1.1583
22420	Flint, MI	MI	1.1325	1.0889
22500	Florence, SC	SC	0.8438	0.8902
22520	Florence-Muscle Shoals, AL	AL	0.8112	0.8665
22540	Fond du Lac, WI	WI	0.9339	0.9542
22660	Fort Collins-Loveland, CO	CO	0.9661	0.9767
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0331	1.0226
22900	Fort Smith, AR-OK	AR	0.7713	0.8371
22900	Fort Smith, AR-OK	OK	0.8021	0.8598
23060	Fort Wayne, IN	IN	0.9252	0.9482
23104	Fort Worth-Arlington, TX	TX	0.9384	0.9574
23420	Fresno, CA	CA	1.1870	1.1246
23460	Gadsden, AL	AL	0.7436	0.8164
23540	Gainesville, FL	FL	0.9372	0.9566
23580	Gainesville, GA	GA	0.9508	0.9660
23844	Gary, IN	IN	0.9088	0.9366
24020	Glens Falls, NY	NY	0.8784	0.9150
24140	Goldsboro, NC	NC	0.9235	0.9470
24220	Grand Forks, ND-MN	MN	0.9100	0.9375
24220	Grand Forks, ND-MN	ND	1.0000	1.0000
24300	Grand Junction, CO	CO	1.0134	1.0092
24340	Grand Rapids-Wyoming, MI	MI	0.9270	0.9494
24500	Great Falls, MT	MT	1.0000	1.0000
24540	Greeley, CO	CO	0.9661	0.9767
24580	Green Bay, WI	WI	0.9395	0.9582
24660	Greensboro-High Point, NC	NC	0.8952	0.9270
24780	Greenville, NC	NC	0.9298	0.9514
24860	Greenville-Mauldin-Easley, SC	SC	0.9404	0.9588
25020	Guayama, PR	PR	0.3559	0.4929
25060	Gulfport-Biloxi, MS	MS	0.8780	0.9148
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9457	0.9625
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9457	0.9625
25260	Hanford-Corcoran, CA	CA	1.1870	1.1246
25420	Harrisburg-Carlisle, PA	PA	0.9157	0.9415
25500	Harrisonburg, VA	VA	0.9250	0.9480
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2501	1.1652
25620	Hattiesburg, MS	MS	0.7910	0.8517

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25860	Hickory-Lenoir-Morganton, NC	NC	0.8608	0.9024
26100	Holland-Grand Haven, MI	MI	0.8752	0.9128
26180	Honolulu, HI	HI	1.1601	1.1070
26300	Hot Springs, AR	AR	0.9249	0.9479
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.7971	0.8562
26420	Houston-Sugar Land-Baytown, TX	TX	0.9902	0.9933
26580	Huntington-Ashland, WV-KY-OH	KY	0.8877	0.9217
26580	Huntington-Ashland, WV-KY-OH	OH	0.8877	0.9217
26580	Huntington-Ashland, WV-KY-OH	WV	0.8877	0.9217
26620	Huntsville, AL	AL	0.9033	0.9327
26820	Idaho Falls, ID	ID	0.9628	0.9744
26900	Indianapolis-Carmel, IN	IN	0.9508	0.9660
26980	Iowa City, IA	IA	0.9507	0.9660
27060	Ithaca, NY	NY	0.9728	0.9813
27100	Jackson, MI	MI	0.9214	0.9455
27140	Jackson, MS	MS	0.8033	0.8607
27180	Jackson, TN	TN	0.8337	0.8829
27260	Jacksonville, FL	FL	0.8872	0.9213
27340	Jacksonville, NC	NC	0.8434	0.8899
27500	Janesville, WI	WI	0.9645	0.9756
27620	Jefferson City, MO	MO	0.8562	0.8991
27740	Johnson City, TN	TN	0.7963	0.8556
27780	Johnstown, PA	PA	0.8521	0.8962
27860	Jonesboro, AR	AR	0.7794	0.8431
27900	Joplin, MO	MO	0.8413	0.8884
28020	Kalamazoo-Portage, MI	MI	1.0261	1.0178
28100	Kankakee-Bradley, IL	IL	1.0518	1.0352
28140	Kansas City, MO-KS	KS	0.9510	0.9662
28140	Kansas City, MO-KS	MO	0.9510	0.9662
28420	Kennewick-Pasco-Richland, WA	WA	1.0068	1.0047
28660	Killeen-Temple-Fort Hood, TX	TX	0.8833	0.9185
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7963	0.8556
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8022	0.8599
28740	Kingston, NY	NY	0.9106	0.9379
28940	Knoxville, TN	TN	0.7963	0.8556
29020	Kokomo, IN	IN	0.8975	0.9286
29100	La Crosse, WI-MN	MN	0.9815	0.9873
29100	La Crosse, WI-MN	WI	0.9815	0.9873
29140	Lafayette, IN	IN	0.9207	0.9450
29180	Lafayette, LA	LA	0.8522	0.8963
29340	Lake Charles, LA	LA	0.8167	0.8705
29404	Lake County-Kenosha County, IL-WI	IL	1.0683	1.0463
29404	Lake County-Kenosha County, IL-WI	WI	1.0683	1.0463
29420	Lake Havasu City-Kingman, AZ	AZ	1.0236	1.0161
29460	Lakeland-Winter Haven, FL	FL	0.8598	0.9017
29540	Lancaster, PA	PA	0.9852	0.9898
29620	Lansing-East Lansing, MI	MI	1.0218	1.0149
29700	Laredo, TX	TX	0.8274	0.8783
29740	Las Cruces, NM	NM	0.9137	0.9401
29820	Las Vegas-Paradise, NV	NV	1.1751	1.1168
29940	Lawrence, KS	KS	0.8470	0.8925
30020	Lawton, OK	OK	0.8574	0.9000
30140	Lebanon, PA	PA	0.8521	0.8962
30300	Lewiston, ID-WA	ID	0.9134	0.9399
30300	Lewiston, ID-WA	WA	1.0068	1.0047
30340	Lewiston-Auburn, ME	ME	0.8911	0.9241
30460	Lexington-Fayette, KY	KY	0.8731	0.9113
30620	Lima, OH	OH	0.9222	0.9460
30700	Lincoln, NE	NE	0.9442	0.9614
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8650	0.9055
30860	Logan, UT-ID	ID	0.8798	0.9160
30860	Logan, UT-ID	UT	0.8798	0.9160
30980	Longview, TX	TX	0.8549	0.8982
31020	Longview, WA	WA	1.0626	1.0425
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2014	1.1339
31140	Louisville-Jefferson County, KY-IN	IN	0.8817	0.9174
31140	Louisville-Jefferson County, KY-IN	KY	0.8817	0.9174
31180	Lubbock, TX	TX	0.8899	0.9232
31340	Lynchburg, VA	VA	0.8514	0.8957
31420	Macon, GA	GA	0.9483	0.9643
31460	Madera-Chowchilla, CA	CA	1.1870	1.1246
31540	Madison, WI	WI	1.1264	1.0849
31700	Manchester-Nashua, NH	NH	1.1003	1.0676
31740	Manhattan, KS	KS	0.7987	0.8573
31860	Mankato-North Mankato, MN	MN	0.9224	0.9462
31900	Mansfield, OH	OH	0.8884	0.9222
32420	Mayagüez, PR	PR	0.3594	0.4962
32580	McAllen-Edinburg-Mission, TX	TX	0.8847	0.9195
32780	Medford, OR	OR	1.0041	1.0028
32820	Memphis, TN-MS-AR	AR	0.9244	0.9476
32820	Memphis, TN-MS-AR	MS	0.9244	0.9476
32820	Memphis, TN-MS-AR	TN	0.9244	0.9476
32900	Merced, CA	CA	1.2111	1.1401
33124	Miami-Miami Beach-Kendall, FL	FL	1.0187	1.0128
33140	Michigan City-La Porte, IN	IN	0.9351	0.9551
33260	Midland, TX	TX	0.9510	0.9662
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0183	1.0125
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0971	1.0655
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0971	1.0655
33540	Missoula, MT	MT	1.0000	1.0000

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33660	Mobile, AL	AL	0.7889	0.8501
33700	Modesto, CA	CA	1.2145	1.1423
33740	Monroe, LA	LA	0.8163	0.8702
33780	Monroe, MI	MI	0.9618	0.9737
33860	Montgomery, AL	AL	0.8579	0.9004
34060	Morgantown, WV	WV	0.8267	0.8778
34100	Morristown, TN	TN	0.7963	0.8556
34580	Mount Vernon-Anacortes, WA	WA	1.0068	1.0047
34620	Muncie, IN	IN	0.8358	0.8844
34740	Muskegon-Norton Shores, MI	MI	0.9800	0.9863
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8665	0.9065
34900	Napa, CA	CA	1.4425	1.2852
34940	Naples-Marco Island, FL	FL	0.9775	0.9845
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9357	0.9555
35004	Nassau-Suffolk, NY	NY	1.2529	1.1670
35084	Newark-Union, NJ-PA	NJ	1.1292	1.0868
35084	Newark-Union, NJ-PA	PA	1.1292	1.0868
35300	New Haven-Milford, CT	CT	1.2501	1.1652
35380	New Orleans-Metairie-Kenner, LA	LA	0.8960	0.9276
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.3122	1.2045
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3122	1.2045
35660	Niles-Benton Harbor, MI	MI	0.8945	0.9265
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9234	0.9469
35980	Norwich-New London, CT	CT	1.2501	1.1652
36084	Oakland-Fremont-Hayward, CA	CA	1.5852	1.3709
36100	Ocala, FL	FL	0.8548	0.8981
36140	Ocean City, NJ	NJ	1.1246	1.0837
36220	Odessa, TX	TX	0.9382	0.9573
36260	Ogden-Clearfield, UT	UT	0.9307	0.9520
36420	Oklahoma City, OK	OK	0.8857	0.9202
36500	Olympia, WA	WA	1.0972	1.0656
36540	Omaha-Council Bluffs, NE-IA	IA	0.9507	0.9660
36540	Omaha-Council Bluffs, NE-IA	NE	0.9507	0.9660
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9164	0.9420
36780	Oshkosh-Neenah, WI	WI	0.9466	0.9631
36980	Owensboro, KY	KY	0.8491	0.8940
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.2318	1.1535
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9300	0.9515
37380	Palm Coast, FL	FL	0.8429	0.8896
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8429	0.8896
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8558	0.8989
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7539	0.8241
37700	Pascagoula, MS	MS	0.8141	0.8686
37764	Peabody, MA	MA	1.0966	1.0652
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8429	0.8896
37900	Peoria, IL	IL	0.9243	0.9475
37964	Philadelphia, PA	PA	1.0754	1.0510
38060	Phoenix-Mesa-Glendale, AZ	AZ	1.0463	1.0315
38220	Pine Bluff, AR	AR	0.8269	0.8780
38300	Pittsburgh, PA	PA	0.8564	0.8993
38340	Pittsfield, MA	MA	1.0430	1.0293
38540	Pocatello, ID	ID	0.9332	0.9538
38660	Ponce, PR	PR	0.4270	0.5584
38860	Portland-South Portland-Biddeford, ME	ME	0.9891	0.9925
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1167	1.0785
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1167	1.0785
38940	Port St. Lucie, FL	FL	1.0725	1.0491
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1384	1.0928
39140	Prescott, AZ	AZ	1.2257	1.1495
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0698	1.0473
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0698	1.0473
39340	Provo-Orem, UT	UT	0.9203	0.9447
39380	Pueblo, CO	CO	0.9661	0.9767
39460	Punta Gorda, FL	FL	0.9038	0.9331
39540	Racine, WI	WI	1.0598	1.0406
39580	Raleigh-Cary, NC	NC	0.9665	0.9769
39660	Rapid City, SD	SD	1.0934	1.0631
39740	Reading, PA	PA	0.8839	0.9190
39820	Redding, CA	CA	1.3551	1.2313
39900	Reno-Sparks, NV	NV	1.0387	1.0263
40060	Richmond, VA	VA	0.9490	0.9648
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1870	1.1246
40220	Roanoke, VA	VA	0.8977	0.9288
40340	Rochester, MN	MN	1.0705	1.0478
40380	Rochester, NY	NY	0.8665	0.9065
40420	Rockford, IL	IL	1.0002	1.0001
40484	Rockingham County-Strafford County, NH	NH	1.1003	1.0676
40580	Rocky Mount, NC	NC	0.9078	0.9359
40660	Rome, GA	GA	0.8548	0.8981
40900	Sacramento-Arden-Arcade-Roseville, CA	CA	1.3602	1.2345
40980	Saginaw-Saginaw Township North, MI	MI	0.9164	0.9420
41060	St. Cloud, MN	MN	1.1595	1.1067
41100	St. George, UT	UT	0.9265	0.9491
41140	St. Joseph, MO-KS	KS	1.0325	1.0221
41140	St. Joseph, MO-KS	MO	1.0325	1.0221
41180	St. Louis, MO-IL	IL	0.9014	0.9314
41180	St. Louis, MO-IL	MO	0.9014	0.9314

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41420	Salem, OR	OR	1.1067	1.0719
41500	Salinas, CA	CA	1.5821	1.3691
41540	Salisbury, MD	MD	0.9258	0.9486
41620	Salt Lake City, UT	UT	0.9316	0.9526
41660	San Angelo, TX	TX	0.8441	0.8904
41700	San Antonio-New Braunfels, TX	TX	0.9030	0.9325
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1870	1.1246
41780	Sandusky, OH	OH	0.8579	0.9004
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5352	1.3412
41900	San Germán-Cabo Rojo, PR	PR	0.4548	0.5830
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6363	1.4010
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4281	0.5593
42020	San Luis Obispo-Paso Robles, CA	CA	1.2371	1.1569
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1954	1.1300
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.1870	1.1246
42100	Santa Cruz-Watsonville, CA	CA	1.6379	1.4020
42140	Santa Fe, NM	NM	1.0734	1.0497
42220	Santa Rosa-Petaluma, CA	CA	1.5765	1.3658
42340	Savannah, GA	GA	0.8816	0.9173
42540	Scranton--Wilkes-Barre, PA	PA	0.8521	0.8962
42644	Seattle-Bellevue-Everett, WA	WA	1.1349	1.0905
42680	Sebastian-Vero Beach, FL	FL	0.9243	0.9475
43100	Sheboygan, WI	WI	0.9253	0.9482
43300	Sherman-Denison, TX	TX	0.8405	0.8878
43340	Shreveport-Bossier City, LA	LA	0.8608	0.9024
43580	Sioux City, IA-NE-SD	IA	0.8924	0.9250
43580	Sioux City, IA-NE-SD	NE	0.8924	0.9250
43580	Sioux City, IA-NE-SD	SD	1.0000	1.0000
43620	Sioux Falls, SD	SD	1.0000	1.0000
43780	South Bend-Mishawaka, IN-MI	IN	0.9839	0.9889
43780	South Bend-Mishawaka, IN-MI	MI	0.9839	0.9889
43900	Spartanburg, SC	SC	0.9167	0.9422
44060	Spokane, WA	WA	1.0547	1.0371
44100	Springfield, IL	IL	0.8903	0.9235
44140	Springfield, MA	MA	1.0342	1.0233
44180	Springfield, MO	MO	0.8485	0.8936
44220	Springfield, OH	OH	0.8965	0.9279
44300	State College, PA	PA	0.8625	0.9037
44600	Steubenville-Weirton, OH-WV	OH	0.8558	0.8989
44600	Steubenville-Weirton, OH-WV	WV	0.7539	0.8241
44700	Stockton, CA	CA	1.2584	1.1705
44940	Sumter, SC	SC	0.8393	0.8869
45060	Syracuse, NY	NY	0.9952	0.9967
45104	Tacoma, WA	WA	1.1220	1.0820
45220	Tallahassee, FL	FL	0.8950	0.9268
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9062	0.9348
45460	Terre Haute, IN	IN	0.9207	0.9450
45500	Texarkana, TX-Texarkana, AR	AR	0.7773	0.8415
45500	Texarkana, TX-Texarkana, AR	TX	0.7976	0.8565
45780	Toledo, OH	OH	0.9340	0.9543
45820	Topeka, KS	KS	0.9092	0.9369
45940	Trenton-Ewing, NJ	NJ	1.1246	1.0837
46060	Tucson, AZ	AZ	0.9643	0.9754
46140	Tulsa, OK	OK	0.8865	0.9208
46220	Tuscaloosa, AL	AL	0.9061	0.9347
46340	Tyler, TX	TX	0.8221	0.8745
46540	Utica-Rome, NY	NY	0.8694	0.9086
46660	Valdosta, GA	GA	0.8108	0.8662
46700	Vallejo-Fairfield, CA	CA	1.4506	1.2901
47020	Victoria, TX	TX	0.8002	0.8584
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1246	1.0837
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8910	0.9240
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8910	0.9240
47300	Visalia-Porterville, CA	CA	1.1870	1.1246
47380	Waco, TX	TX	0.8609	0.9025
47580	Warner Robins, GA	GA	0.8516	0.8958
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9677	0.9778
47894	Washington-Arlington-Alexandria, DC-VA	DC	1.0528	1.0359
47894	Washington-Arlington-Alexandria, DC-VA	MD	1.0528	1.0359
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0528	1.0359
47894	Washington-Arlington-Alexandria, DC-VA	WV	1.0528	1.0359
47940	Waterloo-Cedar Falls, IA	IA	0.8469	0.8924
48140	Wausau, WI	WI	0.9749	0.9827
48300	Wenatchee-East Wenatchee, WA	WA	1.0068	1.0047
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9791	0.9856
48540	Wheeling, WV-OH	OH	0.8558	0.8989
48540	Wheeling, WV-OH	WV	0.7539	0.8241
48620	Wichita, KS	KS	0.8815	0.9173
48660	Wichita Falls, TX	TX	0.9883	0.9920
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0723	1.0490
48864	Wilmington, DE-MD-NJ	MD	1.0723	1.0490
48864	Wilmington, DE-MD-NJ	NJ	1.1246	1.0837
48900	Wilmington, NC	NC	0.9278	0.9500
49020	Winchester, VA-WV	VA	0.9947	0.9964
49020	Winchester, VA-WV	WV	0.9947	0.9964
49180	Winston-Salem, NC	NC	0.8930	0.9254
49340	Worcester, MA	MA	1.1153	1.0776
49420	Yakima, WA	WA	1.0068	1.0047

CBSA Code	Urban Area	State	Wage Index	GAF
49500	Yauco, PR	PR	0.3527	0.4899
49620	York-Hanover, PA	PA	0.9977	0.9984
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8597	0.9017
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8597	0.9017
49700	Yuba City, CA	CA	1.1870	1.1246
49740	Yuma, AZ	AZ	0.9408	0.9591

TABLE 4B.—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 National Rural Floor Budget Neutrality Adjustment)

CBSA Code	Rural Area	State	Wage Index	GAF
01	Alabama	AL	0.7436	0.8164
02	Alaska	AK	1.2573	1.1698
03	Arizona	AZ	0.9088	0.9366
04	Arkansas	AR	0.7479	0.8196
05	California	CA	1.1870	1.1246
06	Colorado	CO	0.9661	0.9767
07	Connecticut	CT	1.2501	1.1652
08	Delaware	DE	1.0040	1.0027
10	Florida	FL	0.8429	0.8896
11	Georgia	GA	0.7747	0.8396
12	Hawaii	HI	1.1343	1.0901
13	Idaho	ID	0.7550	0.8249
14	Illinois	IL	0.8338	0.8830
15	Indiana	IN	0.8358	0.8844
16	Iowa	IA	0.8469	0.8924
17	Kansas	KS	0.7987	0.8573
18	Kentucky	KY	0.7968	0.8559
19	Louisiana	LA	0.7914	0.8520
20	Maine	ME	0.8546	0.8980
21	Maryland	MD	0.9258	0.9486
22	Massachusetts	MA	0.9623	0.9740
23	Michigan	MI	0.8561	0.8991
24	Minnesota	MN	0.9100	0.9375
25	Mississippi	MS	0.7685	0.8350
26	Missouri	MO	0.8119	0.8670
27	Montana	MT	1.0000	1.0000
28	Nebraska	NE	0.8846	0.9195
29	Nevada	NV	1.0000	1.0000
30	New Hampshire	NH	1.1003	1.0676
31	New Jersey[1]	NJ	1.1246	1.0837
32	New Mexico	NM	0.8963	0.9278
33	New York	NY	0.8282	0.8789
34	North Carolina	NC	0.8434	0.8899
35	North Dakota	ND	1.0000	1.0000
36	Ohio	OH	0.8558	0.8989
37	Oklahoma	OK	0.8021	0.8598
38	Oregon	OR	1.0041	1.0028
39	Pennsylvania	PA	0.8521	0.8962
40	Puerto Rico[1]	PR	------	------
41	Rhode Island[1]	RI	------	------
42	South Carolina	SC	0.8393	0.8869
43	South Dakota	SD	1.0000	1.0000
44	Tennessee	TN	0.7963	0.8556
45	Texas	TX	0.7976	0.8565
46	Utah	UT	0.8670	0.9069
47	Vermont	VT	0.9418	0.9598
49	Virginia	VA	0.8022	0.8599
50	Washington	WA	1.0068	1.0047
51	West Virginia	WV	0.7539	0.8241
52	Wisconsin	WI	0.9200	0.9445
53	Wyoming	WY	1.0000	1.0000

[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).

TABLE 4C.—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 National Rural Floor Budget Neutrality Adjustment)

CBSA Code	Area	State	Wage Index	GAF
04	Arkansas	AR	0.7479	0.8196
05	California	CA	1.1870	1.1246
07	Connecticut	CT	1.2501	1.1652
10	Florida	FL	0.8429	0.8896
14	Illinois	IL	0.8338	0.8830
14	Illinois	MO	0.8338	0.8830
16	Iowa	MO	0.8469	0.8924
17	Kansas	KS	0.7987	0.8573
18	Kentucky	KY	0.7968	0.8559
22	Massachusetts	MA	0.9623	0.9740
23	Michigan	MI	0.8561	0.8991

CBSA Code	Area	State	Wage Index	GAF
24	Minnesota	IA	0.9100	0.9375
26	Missouri	AR	0.8119	0.8670
26	Missouri	MO	0.8119	0.8670
28	Nebraska	KS	0.8846	0.9195
30	New Hampshire	NH	1.1003	1.0676
33	New York	NY	0.8282	0.8789
34	North Carolina	NC	0.8434	0.8899
34	North Carolina	TN	0.8434	0.8899
36	Ohio	OH	0.8558	0.8989
37	Oklahoma	OK	0.8021	0.8598
38	Oregon	OR	1.0041	1.0028
39	Pennsylvania	PA	0.8521	0.8962
44	Tennessee	KY	0.7968	0.8559
45	Texas	OK	0.8021	0.8598
45	Texas	TX	0.7976	0.8565
47	Vermont	NY	0.9282	0.9503
49	Virginia	KY	0.8022	0.8599
49	Virginia	VA	0.8022	0.8599
49	Virginia	WV	0.8022	0.8599
50	Washington	WA	1.0068	1.0047
10420	Akron, OH	OH	0.8817	0.9174
10500	Albany, GA	AL	0.8357	0.8843
10500	Albany, GA	GA	0.8357	0.8843
10580	Albany-Schenectady-Troy, NY	NY	0.8664	0.9065
10740	Albuquerque, NM	NM	0.9607	0.9729
10780	Alexandria, LA	LA	0.8137	0.8683
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9370	0.9564
11100	Amarillo, TX	KS	0.8396	0.8872
11100	Amarillo, TX	TX	0.8396	0.8872
11180	Ames, IA	IA	0.9230	0.9466
11260	Anchorage, AK	AK	1.2573	1.1698
11300	Anderson, IN	IN	0.8693	0.9085
11460	Ann Arbor, MI	MI	0.9818	0.9875
12020	Athens-Clarke County, GA	GA	0.9427	0.9604
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9522	0.9670
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9522	0.9670
12260	Augusta-Richmond County, GA-SC	SC	0.9553	0.9692
12420	Austin-Round Rock-San Marcos, TX	TX	0.9480	0.9641
12620	Bangor, ME	ME	0.9646	0.9756
12940	Baton Rouge, LA	MS	0.8545	0.8979
13020	Bay City, MI	MI	0.8846	0.9195
13644	Bethesda-Rockville-Frederick, MD	PA	1.0363	1.0247
13780	Binghamton, NY	PA	0.8747	0.9124
13820	Birmingham-Hoover, AL	AL	0.8409	0.8881
13900	Bismarck, ND	ND	1.0000	1.0000
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7749	0.8398
14020	Bloomington, IN	IN	0.8684	0.9079
14260	Boise City-Nampa, ID	ID	0.9024	0.9321
14484	Boston-Quincy, MA	MA	1.1629	1.1089
14484	Boston-Quincy, MA	RI	1.1629	1.1089
14540	Bowling Green, KY	KY	0.8307	0.8807
14740	Bremerton-Silverdale, WA	WA	1.0358	1.0244
15260	Brunswick, GA	GA	0.9304	0.9518
15380	Buffalo-Niagara Falls, NY	NY	0.9580	0.9710
15540	Burlington-South Burlington, VT	NY	1.0020	1.0014
15540	Burlington-South Burlington, VT	VT	1.0020	1.0014
15764	Cambridge-Newton-Framingham, MA	NH	1.1003	1.0676
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8401	0.8875
16020	Cape Girardeau-Jackson, MO-IL	KY	0.8401	0.8875
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8401	0.8875
16180	Carson City, NV	NV	1.0000	1.0000
16580	Champaign-Urbana, IL	IL	0.9108	0.9380
16620	Charleston, WV	WV	0.8095	0.8653
16700	Charleston-North Charleston-Summerville, SC	SC	0.9272	0.9496
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9087	0.9365
16740	Charlotte-Gastonia-Rock Hill, NC-SC	SC	0.9087	0.9365
16820	Charlottesville, VA	VA	0.9199	0.9444
16860	Chattanooga, TN-GA	AL	0.8635	0.9044
16860	Chattanooga, TN-GA	GA	0.8635	0.9044
16860	Chattanooga, TN-GA	TN	0.8635	0.9044
16974	Chicago-Joliet-Naperville, IL	IL	1.0376	1.0256
16974	Chicago-Joliet-Naperville, IL	IN	1.0376	1.0256
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9589	0.9717
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9589	0.9717
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9589	0.9717
17300	Clarksville, TN-KY	KY	0.7968	0.8559
17460	Cleveland-Elyria-Mentor, OH	OH	0.9051	0.9340
17780	College Station-Bryan, TX	TX	0.9202	0.9446
17860	Columbia, MO	MO	0.8227	0.8749
17900	Columbia, SC	SC	0.8781	0.9148
17980	Columbus, GA-AL	AL	0.8567	0.8995
17980	Columbus, GA-AL	GA	0.8567	0.8995
18140	Columbus, OH	OH	0.9988	0.9992
18580	Corpus Christi, TX	TX	0.8537	0.8973
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8535	0.8972
19124	Dallas-Plano-Irving, TX	TX	0.9561	0.9697
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8615	0.9029
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8615	0.9029
19380	Dayton, OH	OH	0.9138	0.9401
19740	Denver-Aurora-Broomfield, CO	CO	1.0388	1.0264

CBSA Code	Area	State	Wage Index	GAF
19780	Des Moines-West Des Moines, IA	IA	0.9481	0.9642
19804	Detroit-Livonia-Dearborn, MI	MI	0.9738	0.9820
20100	Dover, DE	DE	1.0040	1.0027
20500	Durham-Chapel Hill, NC	NC	0.9443	0.9615
20500	Durham-Chapel Hill, NC	VA	0.9443	0.9615
20764	Edison-New Brunswick, NJ	NJ	1.1246	1.0837
21140	Elkhart-Goshen, IN	IN	0.9409	0.9591
21500	Erie, PA	NY	0.8282	0.8789
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.0981	1.0662
21780	Evansville, IN-KY	KY	0.8112	0.8665
22180	Fayetteville, NC	NC	0.9193	0.9440
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8458	0.8916
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8458	0.8916
22380	Flagstaff, AZ	AZ	1.2088	1.1387
22420	Flint, MI	MI	1.0062	1.0042
22520	Florence-Muscle Shoals, AL	AL	0.8112	0.8665
22520	Florence-Muscle Shoals, AL	MS	0.8112	0.8665
22540	Fond du Lac, WI	WI	0.9200	0.9445
22660	Fort Collins-Loveland, CO	CO	0.9661	0.9767
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0331	1.0226
23060	Fort Wayne, IN	IN	0.9252	0.9482
23104	Fort Worth-Arlington, TX	TX	0.9384	0.9574
23540	Gainesville, FL	FL	0.9372	0.9566
23844	Gary, IN	IN	0.9088	0.9366
24300	Grand Junction, CO	CO	1.0134	1.0092
24340	Grand Rapids-Wyoming, MI	MI	0.9270	0.9494
24500	Great Falls, MT	MT	1.0000	1.0000
24540	Greeley, CO	NE	0.9380	0.9571
24540	Greeley, CO	WY	1.0000	1.0000
24580	Green Bay, WI	MI	0.9203	0.9447
24580	Green Bay, WI	WI	0.9203	0.9447
24660	Greensboro-High Point, NC	NC	0.8952	0.9270
24780	Greenville, NC	NC	0.9147	0.9408
24860	Greenville-Mauldin-Easley, SC	NC	0.9096	0.9372
24860	Greenville-Mauldin-Easley, SC	SC	0.9096	0.9372
25060	Gulfport-Biloxi, MS	MS	0.8276	0.8785
25420	Harrisburg-Carlisle, PA	PA	0.9157	0.9415
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2501	1.1652
25540	Hartford-West Hartford-East Hartford, CT	MA	1.0962	1.0649
25860	Hickory-Lenoir-Morganton, NC	NC	0.8495	0.8943
26300	Hot Springs, AR	AR	0.9026	0.9322
26420	Houston-Sugar Land-Baytown, TX	TX	0.9902	0.9933
26580	Huntington-Ashland, WV-KY-OH	KY	0.8726	0.9109
26580	Huntington-Ashland, WV-KY-OH	NC	0.8726	0.9109
26580	Huntington-Ashland, WV-KY-OH	OH	0.8726	0.9109
26580	Huntington-Ashland, WV-KY-OH	WV	0.8726	0.9109
26620	Huntsville, AL	AL	0.8620	0.9033
26620	Huntsville, AL	TN	0.8620	0.9033
26820	Idaho Falls, ID	ID	0.9628	0.9744
26900	Indianapolis-Carmel, IN	IN	0.9508	0.9660
26980	Iowa City, IA	IA	0.9379	0.9570
27060	Ithaca, NY	NY	0.9141	0.9403
27140	Jackson, MS	MS	0.8033	0.8607
27180	Jackson, TN	MS	0.8337	0.8829
27620	Jefferson City, MO	MO	0.8562	0.8991
27860	Jonesboro, AR	AR	0.7794	0.8431
27900	Joplin, MO	KS	0.8413	0.8884
27900	Joplin, MO	OK	0.8413	0.8884
28020	Kalamazoo-Portage, MI	MI	0.9930	0.9952
28140	Kansas City, MO-KS	KS	0.9510	0.9662
28140	Kansas City, MO-KS	MO	0.9510	0.9662
28420	Kennewick-Pasco-Richland, WA	ID	0.9611	0.9732
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7963	0.8556
28940	Knoxville, TN	KY	0.7968	0.8559
28940	Knoxville, TN	TN	0.7963	0.8556
29180	Lafayette, LA	LA	0.8522	0.8963
29404	Lake County-Kenosha County, IL-WI	IL	1.0505	1.0343
29460	Lakeland-Winter Haven, FL	FL	0.8598	0.9017
29540	Lancaster, PA	PA	0.9852	0.9898
29620	Lansing-East Lansing, MI	MI	1.0044	1.0030
29700	Laredo, TX	TX	0.8274	0.8783
29740	Las Cruces, NM	NM	0.9137	0.9401
29820	Las Vegas-Paradise, NV	AZ	1.1751	1.1168
30020	Lawton, OK	OK	0.8266	0.8777
30460	Lexington-Fayette, KY	KY	0.8604	0.9022
30620	Lima, OH	OH	0.9017	0.9316
30700	Lincoln, NE	NE	0.9442	0.9614
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8461	0.8919
30980	Longview, TX	TX	0.8549	0.8982
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2014	1.1339
31140	Louisville-Jefferson County, KY-IN	KY	0.8817	0.9174
31420	Macon, GA	GA	0.9194	0.9441
31540	Madison, WI	WI	1.1045	1.0704
31700	Manchester-Nashua, NH	NH	1.1003	1.0676
31900	Mansfield, OH	OH	0.8884	0.9222
32780	Medford, OR	OR	1.0041	1.0028
32820	Memphis, TN-MS-AR	AR	0.8920	0.9247
32820	Memphis, TN-MS-AR	MS	0.8920	0.9247

CBSA Code	Area	State	Wage Index	GAF
32820	Memphis, TN-MS-AR	TN	0.8920	0.9247
33124	Miami-Miami Beach-Kendall, FL	FL	1.0187	1.0128
33260	Midland, TX	TX	0.9510	0.9662
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0183	1.0125
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0971	1.0655
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0971	1.0655
33540	Missoula, MT	MT	1.0000	1.0000
33700	Modesto, CA	CA	1.2145	1.1423
33740	Monroe, LA	AR	0.8163	0.8702
33740	Monroe, LA	LA	0.8163	0.8702
33780	Monroe, MI	OH	0.9618	0.9737
33860	Montgomery, AL	AL	0.8579	0.9004
34060	Morgantown, WV	WV	0.8267	0.8778
34740	Muskegon-Norton Shores, MI	MI	0.9343	0.9545
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	NC	0.8665	0.9065
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9245	0.9477
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9245	0.9477
35004	Nassau-Suffolk, NY	CT	1.2501	1.1652
35084	Newark-Union, NJ-PA	NJ	1.1292	1.0868
35084	Newark-Union, NJ-PA	NY	1.1292	1.0868
35084	Newark-Union, NJ-PA	PA	1.1292	1.0868
35300	New Haven-Milford, CT	CT	1.2501	1.1652
35380	New Orleans-Metairie-Kenner, LA	LA	0.8960	0.9276
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2845	1.1870
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2845	1.1870
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2845	1.1870
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9234	0.9469
35980	Norwich-New London, CT	RI	1.1355	1.0909
36084	Oakland-Fremont-Hayward, CA	CA	1.5739	1.3642
36140	Ocean City, NJ	DE	1.0723	1.0490
36220	Odessa, TX	NM	0.9228	0.9465
36220	Odessa, TX	TX	0.9228	0.9465
36260	Ogden-Clearfield, UT	UT	0.9307	0.9520
36420	Oklahoma City, OK	OK	0.8857	0.9202
36500	Olympia, WA	WA	1.0972	1.0656
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9164	0.9420
37460	Panama City-Lynn Haven-Panama City Beach, FL	AL	0.8108	0.8662
37764	Peabody, MA	NH	1.1003	1.0676
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.7981	0.8569
37900	Peoria, IL	IL	0.9133	0.9398
37964	Philadelphia, PA	NJ	1.1246	1.0837
37964	Philadelphia, PA	PA	1.0520	1.0353
38220	Pine Bluff, AR	MS	0.8269	0.8780
38300	Pittsburgh, PA	OH	0.8558	0.8989
38300	Pittsburgh, PA	PA	0.8521	0.8962
38300	Pittsburgh, PA	WV	0.8447	0.8909
38340	Pittsfield, MA	NY	1.0107	1.0073
38340	Pittsfield, MA	VT	1.0107	1.0073
38860	Portland-South Portland-Biddeford, ME	ME	0.9467	0.9632
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1167	1.0785
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1167	1.0785
38940	Port St. Lucie, FL	FL	1.0247	1.0168
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1037	1.0699
39340	Provo-Orem, UT	UT	0.9203	0.9447
39580	Raleigh-Cary, NC	NC	0.9665	0.9769
39740	Reading, PA	PA	0.8839	0.9190
39820	Redding, CA	CA	1.3551	1.2313
39900	Reno-Sparks, NV	NV	1.0387	1.0263
40060	Richmond, VA	VA	0.9490	0.9648
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1410	1.0945
40220	Roanoke, VA	VA	0.8821	0.9177
40220	Roanoke, VA	WV	0.8821	0.9177
40380	Rochester, NY	NY	0.8665	0.9065
40420	Rockford, IL	IL	0.9824	0.9879
40484	Rockingham County-Strafford County, NH	ME	1.0167	1.0114
40900	Sacramento-Arden-Arcade-Roseville, CA	CA	1.3602	1.2345
40980	Saginaw-Saginaw Township North, MI	MI	0.9056	0.9344
41060	St. Cloud, MN	MN	1.0996	1.0672
41100	St. George, UT	UT	0.9265	0.9491
41180	St. Louis, MO-IL	IL	0.8913	0.9242
41180	St. Louis, MO-IL	MO	0.8913	0.9242
41620	Salt Lake City, UT	UT	0.9316	0.9526
41700	San Antonio-New Braunfels, TX	TX	0.9030	0.9325
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6174	1.3899
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1870	1.1246
42100	Santa Cruz-Watsonville, CA	CA	1.6379	1.4020
42140	Santa Fe, NM	NM	1.0348	1.0237
42220	Santa Rosa-Petaluma, CA	CA	1.5477	1.3486
42340	Savannah, GA	GA	0.8816	0.9173
42340	Savannah, GA	SC	0.8816	0.9173
42644	Seattle-Bellevue-Everett, WA	WA	1.1227	1.0825
43300	Sherman-Denison, TX	OK	0.8405	0.8878
43340	Shreveport-Bossier City, LA	LA	0.8608	0.9024
43580	Sioux City, IA-NE-SD	NE	0.8924	0.9250
43620	Sioux Falls, SD	SD	1.0000	1.0000
43780	South Bend-Mishawaka, IN-MI	IN	0.9440	0.9613
43900	Spartanburg, SC	SC	0.9042	0.9334
44060	Spokane, WA	ID	1.0332	1.0226
44100	Springfield, IL	IL	0.8903	0.9235
44180	Springfield, MO	AR	0.8485	0.8936

CBSA Code	Area	State	Wage Index	GAF
44180	Springfield, MO	MO	0.8485	0.8936
44940	Sumter, SC	SC	0.8393	0.8869
45060	Syracuse, NY	NY	0.9952	0.9967
45220	Tallahassee, FL	GA	0.8757	0.9131
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9062	0.9348
45780	Toledo, OH	OH	0.9340	0.9543
45820	Topeka, KS	KS	0.8903	0.9235
46140	Tulsa, OK	OK	0.8760	0.9133
46220	Tuscaloosa, AL	MS	0.8389	0.8867
46340	Tyler, TX	TX	0.8221	0.8745
46540	Utica-Rome, NY	NY	0.8694	0.9086
46660	Valdosta, GA	GA	0.7779	0.8420
46700	Vallejo-Fairfield, CA	CA	1.4304	1.2778
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8910	0.9240
47580	Warner Robins, GA	GA	0.8516	0.8958
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0528	1.0359
48140	Wausau, WI	WI	0.9597	0.9722
48620	Wichita, KS	KS	0.8712	0.9099
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0615	1.0417
48900	Wilmington, NC	SC	0.9278	0.9500
49180	Winston-Salem, NC	NC	0.8930	0.9254
49180	Winston-Salem, NC	VA	0.8930	0.9254
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8521	0.8962

TABLE 4D-2.—STATES DESIGNATED AS FRONTIER, WITH ACUTE CARE HOSPITALS RECEIVING AT A MINIMUM THE FRONTIER STATE FLOOR WAGE INDEX[1]; URBAN AREAS WITH ACUTE CARE HOSPITALS RECEIVING THE STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX--FY 2011

[*Only hospitals that are geographically located in the specified State are protected by the State's frontier, rural, or imputed floor wage index.]

(Wage Index Includes National Rural Floor Budget Neutrality Adjustment Unless a Frontier State Floor Wage Index.)

CBSA Code	State or Urban Area	State*	Frontier, Rural, or Imputed Floor Wage Index
27	Montana	MT	1.0000
29	Nevada	NV	1.0000
35	North Dakota	ND	1.0000
43	South Dakota	SD	1.0000
53	Wyoming	WY	1.0000
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1246
11260	Anchorage, AK	AK	1.2573
12100	Atlantic City-Hammonton, NJ	NJ	1.1246
12540	Bakersfield-Delano, CA	CA	1.1870
13740	Billings, MT	MT	1.0000
13900	Bismarck, ND	ND	1.0000
15804	Camden, NJ	NJ	1.1246
16220	Casper, WY	WY	1.0000
16940	Cheyenne, WY	WY	1.0000
17020	Chico, CA	CA	1.1870
17300	Clarksville, TN-KY	KY	0.7968
17300	Clarksville, TN-KY	TN	0.7963
17420	Cleveland, TN	TN	0.7963
17820	Colorado Springs, CO	CO	0.9661
19060	Cumberland, MD-WV	MD	0.9258
19500	Decatur, IL	IL	0.8338
20100	Dover, DE	DE	1.0040
20764	Edison-New Brunswick, NJ	NJ	1.1246
20940	El Centro, CA	CA	1.1870
21500	Erie, PA	PA	0.8521
21780	Evansville, IN-KY	IN	0.8358
21820	Fairbanks, AK	AK	1.2573
22020	Fargo, ND-MN	MN	0.9100
22020	Fargo, ND-MN	ND	1.0000
22660	Fort Collins-Loveland, CO	CO	0.9661
22900	Fort Smith, AR-OK	OK	0.8021

CBSA Code	State or Urban Area	State*	Frontier, Rural, or Imputed Floor Wage Index
23420	Fresno, CA	CA	1.1870
23460	Gadsden, AL	AL	0.7436
24220	Grand Forks, ND-MN	MN	0.9100
24220	Grand Forks, ND-MN	ND	1.0000
24500	Great Falls, MT	MT	1.0000
24540	Greeley, CO	CO	0.9661
25260	Hanford-Corcoran, CA	CA	1.1870
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2501
27340	Jacksonville, NC	NC	0.8434
27740	Johnson City, TN	TN	0.7963
27780	Johnstown, PA	PA	0.8521
28420	Kennewick-Pasco-Richland, WA	WA	1.0068
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7963
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8022
28940	Knoxville, TN	TN	0.7963
30140	Lebanon, PA	PA	0.8521
30300	Lewiston, ID-WA	WA	1.0068
31460	Madera-Chowchilla, CA	CA	1.1870
31700	Manchester-Nashua, NH	NH	1.1003
31740	Manhattan, KS	KS	0.7987
32780	Medford, OR	OR	1.0041
33540	Missoula, MT	MT	1.0000
34100	Morristown, TN	TN	0.7963
34580	Mount Vernon-Anacortes, WA	WA	1.0068
34620	Muncie, IN	IN	0.8358
35300	New Haven-Milford, CT	CT	1.2501
35980	Norwich-New London, CT	CT	1.2501
36140	Ocean City, NJ	NJ	1.1246
37380	Palm Coast, FL	FL	0.8429
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8429
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8558
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7539
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8429
39380	Pueblo, CO	CO	0.9661
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1870
40484	Rockingham County-Strafford County, NH	NH	1.1003
41540	Salisbury, MD	MD	0.9258
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1870
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.1870
42540	Scranton--Wilkes-Barre, PA	PA	0.8521
43580	Sioux City, IA-NE-SD	SD	1.0000
43620	Sioux Falls, SD	SD	1.0000
44600	Steubenville-Weirton, OH-WV	OH	0.8558
44600	Steubenville-Weirton, OH-WV	WV	0.7539
44940	Sumter, SC	SC	0.8393
45500	Texarkana, TX-Texarkana, AR	TX	0.7976
45940	Trenton-Ewing, NJ	NJ	1.1246
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1246
47300	Visalia-Porterville, CA	CA	1.1870
47940	Waterloo-Cedar Falls, IA	IA	0.8469
48300	Wenatchee-East Wenatchee, WA	WA	1.0068
48540	Wheeling, WV-OH	OH	0.8558
48540	Wheeling, WV-OH	WV	0.7539
48700	Williamsport, PA	PA	0.8521
48864	Wilmington, DE-MD-NJ	NJ	1.1246
49420	Yakima, WA	WA	1.0068
49700	Yuba City, CA	CA	1.1870

[1] Hospitals in frontier States cannot be assigned a wage index of less than 1.0000 under section 10324 of the Affordable Care Act (Pub. L. 111-148).

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

CBSA Code	Urban Area (Constituent Counties)
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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

CBSA Code	Urban Area (Constituent Counties)
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA
14500	Boulder, CO Boulder County, CO
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
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
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
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN
29020	Kokomo, IN Howard County, IN Tipton County, IN
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ
29460	Lakeland-Winter Haven, FL Polk County, FL Winter Haven County, FL
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
33540	Missoula, MT Missoula County, MT
33660	Mobile, AL Mobile County, AL
33700	Modesto, CA Stanislaus County, CA
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA
33780	Monroe, MI Monroe County, MI
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL
34060	Morgantown, WV Monongalia County, WV Preston County, WV
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA
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
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
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA

CBSA Code	Urban Area (Constituent Counties)
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
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
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

CBSA Code	Urban Area (Constituent Counties)
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
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
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI

CBSA Code	Urban Area (Constituent Counties)
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
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX
48700	Williamsport, PA Lycoming County, PA
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC
49340	Worcester, MA Worcester County, MA
49420	Yakima, WA Yakima County, WA
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR
49620	York-Hanover, PA York County, PA
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA
49700	Yuba City, CA Sutter County, CA Yuba County, CA
49740	Yuma, AZ Yuma County, AZ

TABLE 4F.— PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS BY CBSA--FY 2011

(Note: The rural floor budget neutrality adjustment is not applicable to the Puerto Rico specific wage index.)

CBSA Code	Area	Wage Index	GAF	Wage Index– Reclassified Hospitals	GAF– Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.8104	0.8659	------	------
21940	Fajardo, PR	0.9204	0.9448	------	------
25020	Guayama, PR	0.8567	0.8995	------	------
32420	Mayagüez, PR	0.8590	0.9012	------	------
38660	Ponce, PR	1.0230	1.0157	------	------
41900	San Germán-Cabo Rojo, PR	1.0808	1.0547	------	------
41980	San Juan-Caguas-Guaynabo, PR	1.0221	1.0151	------	------
49500	Yauco, PR	0.8382	0.8862	------	------

TABLE 4J.—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 automatically assumed that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wished to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wished to receive the out-migration adjustment, rather than their reclassification, had to follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of the proposed rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act were deemed to have waived the out-migration adjustment, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the FY 2011 IPPS proposed rule.

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0326	MARSHALL	01470
010008		0.0365	CRENSHAW	01200
010010		0.0326	MARSHALL	01470
010012		0.0177	DE KALB	01240
010015		0.0055	CLARKE	01120
010021		0.0052	DALE	01220
010022	*	0.0595	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0026	COFFEE	01150
010029	*	0.0525	LEE	01400
010032		0.0309	RANDOLPH	01550
010035	*	0.0220	CULLMAN	01210
010040		0.0061	ETOWAH	01270
010045		0.0375	FAYETTE	01280
010046	*	0.0061	ETOWAH	01270
010047		0.0266	BUTLER	01060
010049		0.0026	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0575	JACKSON	01350
010065	*	0.0245	TALLAPOOSA	01610
010083	*	0.0153	BALDWIN	01010
010091		0.0055	CLARKE	01120
010100	*	0.0153	BALDWIN	01010
010101	*	0.0188	TALLADEGA	01600
010109		0.0405	PICKENS	01530
010110		0.0450	BULLOCK	01050
010125		0.0425	WINSTON	01660
010128		0.0055	CLARKE	01120
010129		0.0153	BALDWIN	01010
010138		0.0089	SUMTER	01590
010143	*	0.0220	CULLMAN	01210
010150		0.0266	BUTLER	01060
010158	*	0.0121	FRANKLIN	01290
010164	*	0.0188	TALLADEGA	01600
030067		0.0288	LAPAZ	03055
040014	*	0.0161	WHITE	04720
040019		0.0253	ST. FRANCIS	04610
040039	*	0.0055	GREENE	04270
040047		0.0037	RANDOLPH	04600
040067		0.0046	COLUMBIA	04130
040071	*	0.0070	JEFFERSON	04340
040076	*	0.0981	HOT SPRING	04290
040081		0.0398	PIKE	04540
050002	*	0.0055	ALAMEDA	05000
050007		0.0230	SAN MATEO	05510

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050009	*	0.0177	NAPA	05380
050013	*	0.0177	NAPA	05380
050014	*	0.0212	AMADOR	05020
050042	*	0.0254	TEHAMA	05620
050043	*	0.0055	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0230	SAN MATEO	05510
050073	*	0.0295	SOLANO	05580
050075	*	0.0055	ALAMEDA	05000
050089	*	0.0011	SAN BERNARDINO	05460
050099	*	0.0011	SAN BERNARDINO	05460
050101	*	0.0295	SOLANO	05580
050113		0.0230	SAN MATEO	05510
050129	*	0.0011	SAN BERNARDINO	05460
050133		0.0231	YUBA	05680
050140	*	0.0011	SAN BERNARDINO	05460
050150	*	0.0445	NEVADA	05390
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050193	*	0.0013	ORANGE	05400
050195	*	0.0055	ALAMEDA	05000
050197	*	0.0230	SAN MATEO	05510
050211	*	0.0055	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.0055	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.0055	ALAMEDA	05000
050289		0.0230	SAN MATEO	05510
050298		0.0011	SAN BERNARDINO	05460
050300	*	0.0011	SAN BERNARDINO	05460
050305	*	0.0055	ALAMEDA	05000
050320	*	0.0055	ALAMEDA	05000
050325		0.0047	TUOLUMNE	05650
050327	*	0.0011	SAN BERNARDINO	05460
050335	*	0.0047	TUOLUMNE	05650
050348	*	0.0013	ORANGE	05400
050366	*	0.0141	CALAVERAS	05040
050367	*	0.0295	SOLANO	05580
050426	*	0.0013	ORANGE	05400
050444		0.0287	MERCED	05340
050488	*	0.0055	ALAMEDA	05000
050512	*	0.0055	ALAMEDA	05000
050517	*	0.0011	SAN BERNARDINO	05460
050526	*	0.0013	ORANGE	05400
050528	*	0.0287	MERCED	05340
050541	*	0.0230	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050586	*	0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667	*	0.0177	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0295	SOLANO	05580
050693	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050754		0.0230	SAN MATEO	05510
050758	*	0.0011	SAN BERNARDINO	05460
060001	*	0.0096	WELD	06610
060003	*	0.0101	BOULDER	06060
060027	*	0.0101	BOULDER	06060
060103	*	0.0101	BOULDER	06060
060116	*	0.0101	BOULDER	06060
060121		0.0096	WELD	06610
080001		0.0044	NEW CASTLE	08010
080003		0.0044	NEW CASTLE	08010
090001		0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004		0.0033	THE DISTRICT	09000

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090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000
090008		0.0033	THE DISTRICT	09000
090011		0.0033	THE DISTRICT	09000
100014	*	0.0058	VOLUSIA	10630
100017	*	0.0058	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0058	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0058	VOLUSIA	10630
100072	*	0.0058	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0250	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0068	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0258	OKEECHOBEE	10460
100290	*	0.0338	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0247	GORDON	11500
110029	*	0.0002	HALL	11550
110040	*	0.1219	JACKSON	11610
110041	*	0.0704	HABERSHAM	11540
110100		0.0821	JEFFERSON	11620
110101		0.0070	COOK	11311
110142		0.0192	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0209	BALDWIN	11030
110187	*	0.0727	LUMPKIN	11701
110189	*	0.0046	FANNIN	11450
110190	*	0.0106	MACON	11710
110205		0.0466	GILMER	11471
130003	*	0.0165	NEZ PERCE	13340
130024		0.0687	BONNER	13080
130049	*	0.0365	KOOTENAI	13270
130066		0.0365	KOOTENAI	13270
130067	*	0.1031	BINGHAM	13050
140001		0.0321	FULTON	14370
140026		0.0302	LA SALLE	14580
140043	*	0.0036	WHITESIDE	14988
140058	*	0.0119	MORGAN	14770
140110	*	0.0302	LA SALLE	14580
140116	*	0.0014	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0178	LIVINGSTON	14610
140167	*	0.0769	IROQUOIS	14460
140176	*	0.0014	MC HENRY	14640
140234		0.0302	LA SALLE	14580
150022		0.0251	MONTGOMERY	15530
150030	*	0.0242	HENRY	15320
150072		0.0093	CASS	15080
150076	*	0.0296	MARSHALL	15490
150088	*	0.0038	MADISON	15470
150091	*	0.0095	HUNTINGTON	15340
150102	*	0.0179	STARKE	15740
150113	*	0.0038	MADISON	15470
150133	*	0.0211	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
160013		0.0192	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0349	JASPER	16490
160080	*	0.0023	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0143	COWLEY	17170
180012	*	0.0094	HARDIN	18460
180017	*	0.0090	BARREN	18040
180049	*	0.0312	MADISON	18750
180064		0.0201	MONTGOMERY	18860
180066		0.0523	LOGAN	18700
180070		0.0112	GRAYSON	18420
180079		0.0166	HARRISON	18480
190003	*	0.0070	IBERIA	19220
190015	*	0.0237	TANGIPAHOA	19520
190017	*	0.0156	ST. LANDRY	19480
190034		0.0156	VERMILION	19560
190044		0.0215	ACADIA	19000
190050		0.0056	BEAUREGARD	19050
190053		0.0107	JEFFRSON DAVIS	19260
190054		0.0070	IBERIA	19220
190078		0.0156	ST. LANDRY	19480

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190086	*	0.0054	LINCOLN	19300
190088		0.0278	WEBSTER	19590
190099		0.0108	AVOYELLES	19040
190106	*	0.0082	ALLEN	19010
190116		0.0074	MOREHOUSE	19330
190133		0.0082	ALLEN	19010
190140		0.0030	FRANKLIN	19200
190144	*	0.0278	WEBSTER	19590
190145		0.0051	LA SALLE	19290
190184		0.0075	CALDWELL	19100
190190	*	0.0075	CALDWELL	19100
190191		0.0156	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0054	LINCOLN	19300
200024	*	0.0131	ANDROSCOGGIN	20000
200032		0.0367	OXFORD	20080
200034	*	0.0131	ANDROSCOGGIN	20000
200050	*	0.0169	HANCOCK	20040
210001		0.0096	WASHINGTON	21210
210023		0.0035	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0035	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002		0.0438	MIDDLESEX	22090
220010	*	0.0307	ESSEX	22040
220011		0.0438	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025		0.0072	WORCESTER	22170
220029	*	0.0307	ESSEX	22040
220033	*	0.0307	ESSEX	22040
220035	*	0.0307	ESSEX	22040
220049		0.0438	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063		0.0438	MIDDLESEX	22090
220070		0.0438	MIDDLESEX	22090
220080	*	0.0307	ESSEX	22040
220082		0.0438	MIDDLESEX	22090
220084		0.0438	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170
220098		0.0438	MIDDLESEX	22090
220101		0.0438	MIDDLESEX	22090
220105		0.0438	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170
220171		0.0438	MIDDLESEX	22090
220174	*	0.0307	ESSEX	22040
220175		0.0438	MIDDLESEX	22090
220176	*	0.0072	WORCESTER	22170
230002	*	0.0043	WAYNE	23810
230003	*	0.0317	OTTAWA	23690
230005		0.0489	LENAWEE	23450
230013	*	0.0023	OAKLAND	23620
230015		0.0314	ST. JOSEPH	23740
230019	*	0.0023	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0159	BERRIEN	23100
230022	*	0.0214	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0023	OAKLAND	23620
230035	*	0.0144	MONTCALM	23580
230037	*	0.0235	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0020	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230071	*	0.0023	OAKLAND	23620
230072	*	0.0317	OTTAWA	23690
230075		0.0066	CALHOUN	23120
230078	*	0.0159	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0205	JACKSON	23370
230093		0.0088	MECOSTA	23530
230096	*	0.0314	ST. JOSEPH	23740
230099	*	0.0075	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0923	SHIAWASSEE	23770
230130	*	0.0023	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0023	OAKLAND	23620

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230165	*	0.0043	WAYNE	23810
230174	*	0.0317	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0020	MACOMB	23490
230204	*	0.0020	MACOMB	23490
230207	*	0.0023	OAKLAND	23620
230208	*	0.0144	MONTCALM	23580
230217		0.0066	CALHOUN	23120
230222	*	0.0098	MIDLAND	23550
230227	*	0.0020	MACOMB	23490
230244	*	0.0043	WAYNE	23810
230254	*	0.0023	OAKLAND	23620
230257	*	0.0020	MACOMB	23490
230264	*	0.0020	MACOMB	23490
230269	*	0.0023	OAKLAND	23620
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0023	OAKLAND	23620
230297	*	0.0043	WAYNE	23810
230301	*	0.0023	OAKLAND	23620
230302	*	0.0023	OAKLAND	23620
240018		0.0922	GOODHUE	24240
240044		0.0732	WINONA	24840
240064		0.0227	ITASCA	24300
240069	*	0.0312	STEELE	24730
240071	*	0.0404	RICE	24650
240101		0.0146	BECKER	24020
240117		0.0614	MOWER	24490
240211		0.1038	PINE	24570
250023	*	0.0726	PEARL RIVER	25540
250040	*	0.0195	JACKSON	25290
250117	*	0.0726	PEARL RIVER	25540
250128		0.0445	PANOLA	25530
250162		0.0025	HANCOCK	25220
260059		0.0044	LACLEDE	26520
260064		0.0038	AUDRAIN	26030
260097		0.0358	JOHNSON	26500
260116	*	0.0094	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0094	ST. FRANCOIS	26930
280077	*	0.0084	DODGE	28260

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290002	*	0.0148	LYON	29090
300011	*	0.0049	HILLSBOROUGH	30050
300012	*	0.0049	HILLSBOROUGH	30050
300017	*	0.0075	ROCKINGHAM	30070
300020	*	0.0049	HILLSBOROUGH	30050
300023	*	0.0075	ROCKINGHAM	30070
300029	*	0.0075	ROCKINGHAM	30070
300034	*	0.0049	HILLSBOROUGH	30050
310002	*	0.0315	ESSEX	31200
310009	*	0.0315	ESSEX	31200
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310038	*	0.0239	MIDDLESEX	31270
310039	*	0.0239	MIDDLESEX	31270
310050	*	0.0199	MORRIS	31300
310054	*	0.0315	ESSEX	31200
310070	*	0.0239	MIDDLESEX	31270
310076	*	0.0315	ESSEX	31200
310083	*	0.0315	ESSEX	31200
310096	*	0.0315	ESSEX	31200
310108	*	0.0239	MIDDLESEX	31270
310119	*	0.0315	ESSEX	31200
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
330004	*	0.0916	ULSTER	33740
330008	*	0.0085	WYOMING	33900
330010		0.0079	MONTGOMERY	33380
330027	*	0.0207	NASSAU	33400
330033		0.0233	CHENANGO	33080
330047		0.0079	MONTGOMERY	33380
330073	*	0.0103	GENESEE	33290
330094	*	0.0579	COLUMBIA	33200
330103		0.0153	CATTARAUGUS	33040
330106	*	0.0207	NASSAU	33400
330126	*	0.0491	ORANGE	33540
330132		0.0153	CATTARAUGUS	33040
330135		0.0491	ORANGE	33540
330144		0.0056	STEUBEN	33690
330151		0.0056	STEUBEN	33690
330167	*	0.0207	NASSAU	33400
330175		0.0273	CORTLAND	33210

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330181	*	0.0207	NASSAU	33400
330182	*	0.0207	NASSAU	33400
330198	*	0.0207	NASSAU	33400
330205		0.0491	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0916	ULSTER	33740
330225	*	0.0207	NASSAU	33400
330235	*	0.0316	CAYUGA	33050
330259	*	0.0207	NASSAU	33400
330264		0.0491	ORANGE	33540
330276		0.0043	FULTON	33280
330277	*	0.0056	STEUBEN	33690
330331	*	0.0207	NASSAU	33400
330332	*	0.0207	NASSAU	33400
330372	*	0.0207	NASSAU	33400
330386	*	0.0853	SULLIVAN	33710
340020		0.0163	LEE	34520
340021	*	0.0143	CLEVELAND	34220
340024		0.0143	SAMPSON	34810
340027	*	0.0164	LENOIR	34530
340037	*	0.0143	CLEVELAND	34220
340038		0.0329	BEAUFORT	34060
340039	*	0.0090	IREDELL	34480
340068	*	0.0111	COLUMBUS	34230
340070		0.0289	ALAMANCE	34000
340071	*	0.0260	HARNETT	34420
340085	*	0.0259	DAVIDSON	34280
340096	*	0.0259	DAVIDSON	34280
340126	*	0.0130	WILSON	34970
340129	*	0.0090	IREDELL	34480
340133		0.0260	MARTIN	34580
340144	*	0.0090	IREDELL	34480
340145	*	0.0306	LINCOLN	34540
340151		0.0084	HALIFAX	34410
360002		0.0092	ASHLAND	36020
360010	*	0.0012	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0065	ERIE	36220
360036	*	0.0146	WAYNE	36860
360040		0.0445	KNOX	36430
360044		0.0127	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0053	HURON	36400
360070		0.0005	STARK	36770
360071		0.0071	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0086	CLARK	36110
360096		0.0011	COLUMBIANA	36140
360107		0.0163	SANDUSKY	36730
360125	*	0.0099	ASHTABULA	36030
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0163	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0192	CLINTON	36130
360185		0.0011	COLUMBIANA	36140
360245	*	0.0099	ASHTABULA	36030
360355		0.0086	CLARK	36110
360356		0.0163	SANDUSKY	36730
370014	*	0.0167	BRYAN	37060
370015	*	0.0388	MAYES	37480
370023		0.0071	STEPHENS	37680
370065		0.0102	CRAIG	37170
370149	*	0.0240	POTTAWATOMIE	37620
370156		0.0096	GARVIN	37240
370169		0.0173	MCINTOSH	37450
370214		0.0096	GARVIN	37240
380022		0.0126	LINN	38210
390008		0.0011	LAWRENCE	39450
390016	*	0.0011	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044	*	0.0250	BERKS	39110
390052		0.0018	CLEARFIELD	39230
390056		0.0022	HUNTINGDON	39380
390065	*	0.0591	ADAMS	39000
390066	*	0.0269	LEBANON	39460
390086	*	0.0018	CLEARFIELD	39230
390096	*	0.0250	BERKS	39110
390110	*	0.0006	CAMBRIA	39160
390112		0.0037	SOMERSET	39680

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390117		0.0008	BEDFORD	39100
390130	*	0.0006	CAMBRIA	39160
390138	*	0.0204	FRANKLIN	39350
390150		0.0005	GREENE	39370
390151	*	0.0204	FRANKLIN	39350
390162	*	0.0217	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.0945	MONROE	39550
390313	*	0.0147	SCHUYLKILL	39650
390316	*	0.0250	BERKS	39110
420002		0.0001	YORK	42450
420005		0.0013	DILLON	42160
420007		0.0027	SPARTANBURG	42410
420019		0.0170	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027	*	0.0157	ANDERSON	42030
420030	*	0.0153	COLLETON	42140
420036	*	0.0075	LANCASTER	42280
420039	*	0.0110	UNION	42430
420043		0.0175	CHEROKEE	42100
420053		0.0111	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420055		0.0032	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0072	ORANGEBURG	42370
420069	*	0.0006	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083		0.0027	SPARTANBURG	42410
420098		0.0008	GEORGETOWN	42210
430048		0.0353	LAWRENCE	43400
430094		0.0353	LAWRENCE	43400
440007		0.0179	COFFEE	44150
440008		0.0249	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0080	CARROLL	44080
440017		0.0009	SULLIVAN	44810
440025	*	0.0009	GREENE	44290
440035	*	0.0300	MONTGOMERY	44620
440047		0.0188	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0045	MC NAIRY	44540
440060		0.0188	GIBSON	44260
440063		0.0033	WASHINGTON	44890
440070		0.0060	DECATUR	44190
440105		0.0033	WASHINGTON	44890
440109		0.0039	HARDIN	44350
440115		0.0188	GIBSON	44260
440137		0.0605	BEDFORD	44010
440144	*	0.0179	COFFEE	44150
440148		0.0242	DE KALB	44200
440174	*	0.0235	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440181		0.0306	HARDEMAN	44340
440182		0.0080	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0254	BRADLEY	44050
450032	*	0.0216	HARRISON	45620
450039	*	0.0054	TARRANT	45910
450052	*	0.0333	BOSQUE	45160
450064	*	0.0054	TARRANT	45910
450087	*	0.0054	TARRANT	45910
450090		0.0711	COOKE	45340
450099	*	0.0085	GRAY	45563
450135	*	0.0054	TARRANT	45910
450137	*	0.0054	TARRANT	45910
450144	*	0.0447	ANDREWS	45010
450163		0.0116	KLEBERG	45743
450192		0.0316	HILL	45651
450194		0.0053	CHEROKEE	45281
450210		0.0128	PANOLA	45842
450224	*	0.0056	WOOD	45974
450236		0.0426	HOPKINS	45654
450270		0.0316	HILL	45651
450283	*	0.0422	VAN ZANDT	45947
450347	*	0.0396	WALKER	45949
450348	*	0.0094	FALLS	45500
450370	*	0.0251	COLORADO	45312
450389	*	0.0413	HENDERSON	45640
450395		0.0472	POLK	45850
450419	*	0.0054	TARRANT	45910

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
450438	*	0.0251	COLORADO	45312
450451		0.0524	SOMERVELL	45893
450460		0.0056	TYLER	45942
450497		0.0516	MONTAGUE	45800
450539		0.0139	HALE	45582
450547	*	0.0056	WOOD	45974
450563	*	0.0054	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0133	JASPER	45690
450596	*	0.0727	HOOD	45653
450597		0.0004	DE WITT	45420
450615		0.0033	CASS	45260
450639	*	0.0054	TARRANT	45910
450641		0.0516	MONTAGUE	45800
450672	*	0.0054	TARRANT	45910
450675	*	0.0054	TARRANT	45910
450677	*	0.0054	TARRANT	45910
450698		0.0264	LAMB	45751
450747	*	0.0031	ANDERSON	45000
450755		0.0575	HOCKLEY	45652
450770	*	0.0219	MILAM	45795
450779	*	0.0054	TARRANT	45910
450813		0.0031	ANDERSON	45000
450872	*	0.0054	TARRANT	45910
450880	*	0.0054	TARRANT	45910
450886	*	0.0054	TARRANT	45910
450888		0.0054	TARRANT	45910
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0229	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0229	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1048	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0236	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0176	MONTGOMERY	49600
500003	*	0.0270	SKAGIT	50280
500007	*	0.0270	SKAGIT	50280
500019		0.0166	LEWIS	50200
500024		0.0064	THURSTON	50330
500039	*	0.0182	KITSAP	50170
500041	*	0.0055	COWLITZ	50070
500139		0.0064	THURSTON	50330
500143		0.0064	THURSTON	50330
510012		0.0110	MASON	51260
510018	*	0.0106	JACKSON	51170
510047	*	0.0233	MARION	51240
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0413	GREEN	52220
520035		0.0112	SHEBOYGAN	52580
520044		0.0112	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0268	SAUK	52550
520071	*	0.0267	JEFFERSON	52270
520076	*	0.0219	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0268	SAUK	52550
520102		0.0599	WALWORTH	52630
520116	*	0.0267	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--FY 2011

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.3441	31.6	41.9
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.6127	17.6	22.6

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.1239	30.1	36.6
004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2403	22.2	27.1
005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.1771	14.9	19.9
006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8353	8.3	9.3
007	No	No	PRE	SURG	LUNG TRANSPLANT	9.3350	15.4	18.6
008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9632	10.1	11.7
010	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.7831	8.6	9.7
011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7666	12.3	15.5
012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.1311	8.5	10.1
013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9505	5.7	6.8
014	No	No	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.5947	21.1	28.2
015	No	No	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT	5.9504	16.7	19.3
020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2479	14.1	17.3
021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2886	12.1	13.9
022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.1581	6.7	8.4
023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	5.0883	8.2	11.8
024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.4952	5.7	8.1
025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.7575	8.8	11.5
026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9825	5.8	7.3
027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1307	3.0	3.9
028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.3549	10.1	13.1
029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.8741	4.7	6.6
030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6433	2.5	3.3
031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1261	8.6	12.3
032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9220	3.6	5.3
033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3626	2.1	2.6
034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5242	4.7	7.0
035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.1437	2.2	3.2
036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.6390	1.3	1.5
037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1543	5.7	8.4
038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5462	2.4	3.5
039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0185	1.4	1.7
040	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9353	9.0	12.1
041	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1430	5.0	6.7
042	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6905	2.4	3.2
052	No	No	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.6109	4.5	6.7

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
053	No	No	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8441	2.9	3.6
054	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.4863	4.6	6.3
055	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0649	3.5	4.6
056	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6748	5.5	7.1
057	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9350	3.7	4.8
058	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5856	5.4	7.2
059	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	0.9811	4.1	4.9
060	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7578	3.2	3.8
061	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.9568	6.4	8.4
062	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9479	4.8	5.6
063	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5251	3.4	3.9
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8674	5.1	6.9
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1667	4.0	4.8
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8198	2.7	3.3
067	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4231	4.2	5.5
068	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8751	2.7	3.3
069	No	No	01	MED	TRANSIENT ISCHEMIA	0.7311	2.3	2.8
070	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.8417	5.6	7.3
071	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1054	4.1	5.1
072	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7499	2.5	3.1
073	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2907	4.2	5.6
074	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8606	3.2	4.1
075	No	No	01	MED	VIRAL MENINGITIS W CC/MCC	1.6567	5.5	7.0
076	No	No	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.9050	3.3	3.9
077	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.7376	5.1	6.4
078	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	1.0154	3.5	4.4
079	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7533	2.6	3.1
080	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1909	3.6	4.9
081	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7392	2.7	3.4
082	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0130	3.5	6.1
083	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3264	3.4	4.7
084	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8959	2.2	2.8
085	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1423	5.2	7.2
086	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2051	3.7	4.6
087	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7929	2.3	2.9
088	No	No	01	MED	CONCUSSION W MCC	1.4872	4.2	5.5
089	No	No	01	MED	CONCUSSION W CC	0.9667	2.9	3.7
090	No	No	01	MED	CONCUSSION W/O CC/MCC	0.6927	1.9	2.3
091	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6318	4.4	6.2
092	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9404	3.3	4.2
093	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O	0.6827	2.4	2.9

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					CC/MCC			
094	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6769	8.9	11.7
095	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3977	6.6	8.4
096	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	1.9247	4.6	5.6
097	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.2191	9.0	11.6
098	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.9106	6.4	7.9
099	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2084	4.1	5.2
100	Yes	No	01	MED	SEIZURES W MCC	1.5107	4.5	6.0
101	Yes	No	01	MED	SEIZURES W/O MCC	0.7619	2.8	3.4
102	No	No	01	MED	HEADACHES W MCC	1.0288	3.1	4.3
103	No	No	01	MED	HEADACHES W/O MCC	0.6701	2.4	3.0
113	No	No	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.8311	3.9	5.6
114	No	No	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.8989	2.0	2.6
115	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.2084	3.5	4.6
116	No	No	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.2675	3.0	4.4
117	No	No	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.7305	1.6	2.0
121	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9104	4.1	5.1
122	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6522	3.3	4.0
123	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7144	2.2	2.7
124	No	No	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1903	3.8	5.3
125	No	No	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6859	2.7	3.4
129	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR	2.2349	3.7	5.2
					MAJOR DEVICE			
130	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2299	2.3	2.9
131	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.0915	4.1	5.6
132	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.2447	2.1	2.7
133	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.7000	3.6	5.4
134	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8514	1.7	2.1
135	No	No	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.9082	4.3	6.4
136	No	No	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	0.9751	1.7	2.3
137	No	No	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3007	3.6	5.0
138	No	No	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7841	1.9	2.5
139	No	No	03	SURG	SALIVARY GLAND PROCEDURES	0.8756	1.4	1.8
146	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.1886	6.5	9.1
147	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2413	4.1	5.7
148	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8066	2.4	3.3
149	No	No	03	MED	DYSEQUILIBRIUM	0.6389	2.2	2.6
150	No	No	03	MED	EPISTAXIS W MCC	1.2808	3.7	5.0
151	No	No	03	MED	EPISTAXIS W/O MCC	0.6393	2.3	2.9
152	No	No	03	MED	OTITIS MEDIA & URI W MCC	0.9584	3.3	4.3
153	No	No	03	MED	OTITIS MEDIA & URI W/O MCC	0.6290	2.5	3.1
154	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.3965	4.3	5.8
155	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.9017	3.3	4.2
156	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6226	2.4	2.9
157	No	No	03	MED	DENTAL & ORAL DISEASES W MCC	1.5794	4.8	6.7
158	No	No	03	MED	DENTAL & ORAL DISEASES W CC	0.9027	3.4	4.4

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
159	No	No	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5897	2.2	2.7
163	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.0828	11.5	14.0
164	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6236	6.2	7.4
165	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7758	3.7	4.4
166	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7383	9.5	11.9
167	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0567	5.8	7.4
168	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3008	3.3	4.3
175	Yes	No	04	MED	PULMONARY EMBOLISM W MCC	1.6096	5.7	6.8
176	Yes	No	04	MED	PULMONARY EMBOLISM W/O MCC	1.0706	4.2	4.9
177	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0667	6.8	8.5
178	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4887	5.6	6.8
179	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9861	4.1	5.0
180	No	No	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7361	5.7	7.5
181	No	No	04	MED	RESPIRATORY NEOPLASMS W CC	1.2182	4.2	5.4
182	No	No	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8096	2.8	3.7
183	No	No	04	MED	MAJOR CHEST TRAUMA W MCC	1.4942	5.2	6.5
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9755	3.6	4.3
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6803	2.6	3.0
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5637	5.3	6.7
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.1027	3.9	4.9
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7678	2.8	3.5
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2809	4.3	5.5
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1924	4.5	5.5
191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9735	3.8	4.6
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE	0.7220	3.1	3.7
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4796	5.3	6.5
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	1.0152	4.2	5.0
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7096	3.1	3.7
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6062	5.6	6.9
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1176	4.2	5.1
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8203	3.1	3.8
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.7895	6.3	8.0
200	No	No	04	MED	PNEUMOTHORAX W CC	1.0252	3.7	4.8
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7210	2.8	3.6
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8424	3.4	4.1
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6081	2.6	3.2
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6714	2.1	2.7
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.2972	3.9	5.3
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7575	2.6	3.3
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.2068	12.6	14.7
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2630	5.1	7.0
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.6086	6.9	12.2
216	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	10.0238	14.6	17.0
217	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.8038	9.8	10.9
218	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.3293	7.2	8.0
219	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ	8.0831	10.8	13.1

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					CARDIOTHORACIC PROC W/O CARD CATH W MCC			
220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.3787	7.2	8.0
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.4801	5.6	6.0
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.5230	9.4	11.8
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.4250	4.5	6.2
224	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.5819	7.7	9.7
225	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	6.0202	4.2	5.3
226	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.4510	5.0	7.7
227	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.1936	2.0	3.1
228	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.5881	11.8	14.2
229	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.7745	7.2	8.3
230	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.5451	4.6	5.5
231	No	No	05	SURG	CORONARY BYPASS W PTCA W MCC	7.8582	10.9	12.9
232	No	No	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.8183	8.5	9.4
233	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.2081	12.1	13.7
234	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.8281	8.2	8.9
235	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8530	9.3	10.8
236	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.7707	6.0	6.5
237	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.1903	7.1	10.1
238	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	3.0830	2.9	4.2
239	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.5544	11.2	14.3
240	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6589	7.8	9.6
241	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4631	5.0	6.0
242	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7277	6.3	8.1
243	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6508	3.9	4.9
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.0398	2.2	2.8
245	No	No	05	SURG	AICD GENERATOR PROCEDURES	4.2486	2.5	3.8
246	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.1802	3.5	5.0
247	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9691	1.8	2.3
248	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	2.9248	4.4	6.0
249	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.7732	2.2	2.8
250	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.8836	5.0	7.0
251	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.7992	2.2	3.0
252	No	No	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9754	5.2	7.9
253	No	No	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4014	4.4	6.0
254	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.6152	2.0	2.7

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
255	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5043	7.0	9.2
256	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.5969	5.6	7.0
257	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9750	3.4	4.3
258	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.8880	5.2	7.0
259	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.8334	2.4	3.2
260	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.5500	7.7	10.7
261	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.6469	3.2	4.5
262	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.1246	2.0	2.6
263	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.7565	3.5	5.6
264	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.5305	5.5	8.2
265	No	No	05	SURG	AICD LEAD PROCEDURES	2.3157	2.3	3.4
280	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.8503	5.2	6.6
281	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1912	3.6	4.4
282	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.8064	2.2	2.8
283	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7151	3.2	5.1
284	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.8888	2.1	3.0
285	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5712	1.4	1.8
286	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.0014	4.8	6.5
287	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0879	2.5	3.2
288	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.9397	8.6	10.8
289	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8492	6.4	7.8
290	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.2959	4.4	5.6
291	Yes	No	05	MED	HEART FAILURE & SHOCK W MCC	1.4943	4.8	6.2
292	Yes	No	05	MED	HEART FAILURE & SHOCK W CC	1.0302	4.0	4.9
293	Yes	No	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6853	2.8	3.3
294	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0373	4.4	5.4
295	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6403	3.4	4.0
296	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.1692	1.8	2.8
297	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6792	1.4	1.7
298	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4497	1.1	1.2
299	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4072	4.7	6.1
300	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9776	3.9	4.9
301	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6615	2.8	3.5
302	No	No	05	MED	ATHEROSCLEROSIS W MCC	0.9755	3.0	4.0
303	No	No	05	MED	ATHEROSCLEROSIS W/O MCC	0.5830	2.0	2.4
304	No	No	05	MED	HYPERTENSION W MCC	1.0263	3.5	4.6
305	No	No	05	MED	HYPERTENSION W/O MCC	0.6138	2.2	2.8
306	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4667	4.4	5.9
307	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7974	2.7	3.4

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
308	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2339	4.0	5.2
309	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8387	3.0	3.7
310	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5709	2.1	2.5
311	No	No	05	MED	ANGINA PECTORIS	0.5070	1.8	2.2
312	No	No	05	MED	SYNCOPE & COLLAPSE	0.7172	2.4	2.9
313	No	No	05	MED	CHEST PAIN	0.5499	1.7	2.1
314	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.8145	5.0	6.8
315	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9681	3.3	4.2
316	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6147	2.1	2.6
326	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.8142	12.6	16.2
327	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.7231	6.9	8.8
328	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.4298	2.9	3.8
329	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.2807	12.5	15.4
330	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5830	7.8	9.1
331	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6267	4.8	5.3
332	Yes	No	06	SURG	RECTAL RESECTION W MCC	4.8635	11.8	14.2
333	Yes	No	06	SURG	RECTAL RESECTION W CC	2.4960	7.1	8.1
334	Yes	No	06	SURG	RECTAL RESECTION W/O CC/MCC	1.5979	4.2	4.9
335	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.2777	11.4	13.7
336	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3456	7.2	8.8
337	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4789	4.0	5.1
338	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.2115	8.3	10.0
339	No	No	06	SURG	APPENDECTOMY W	1.8659	5.6	6.5
					COMPLICATED PRINCIPAL DIAG W CC			
340	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2393	3.2	3.7
341	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2643	4.9	6.6
342	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3246	3.0	3.8
343	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9568	1.7	2.0
344	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.1586	8.9	11.2
345	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.7035	6.0	7.0
346	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1883	4.2	4.6
347	No	No	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4183	6.3	8.8
348	No	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3705	4.1	5.4
349	No	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.7981	2.3	2.9
350	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4877	5.6	7.9
351	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.3539	3.5	4.5
352	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8628	1.9	2.4
353	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.7510	6.3	8.4
354	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.5523	4.0	5.0
355	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.0329	2.3	2.8
356	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	4.0293	9.2	12.7
357	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1466	5.7	7.4
358	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O	1.3010	3.0	4.0

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					CC/MCC			
368	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.7578	5.1	6.7
369	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0772	3.7	4.5
370	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7546	2.6	3.1
371	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	2.0986	6.8	8.8
372	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2935	5.3	6.5
373	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8599	3.9	4.6
374	Yes	No	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0674	6.3	8.4
375	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.2801	4.4	5.8
376	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8478	2.8	3.6
377	Yes	No	06	MED	G.I. HEMORRHAGE W MCC	1.7541	5.0	6.4
378	Yes	No	06	MED	G.I. HEMORRHAGE W CC	1.0274	3.5	4.2
379	Yes	No	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7146	2.6	3.0
380	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9656	5.8	7.6
381	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W CC	1.1207	3.9	4.8
382	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8130	2.9	3.5
383	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.1982	4.2	5.3
384	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8326	3.0	3.6
385	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.9102	6.3	8.4
386	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0435	4.2	5.3
387	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7813	3.2	3.9
388	Yes	No	06	MED	G.I. OBSTRUCTION W MCC	1.6457	5.5	7.2
389	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9344	3.9	4.8
390	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6369	2.8	3.3
391	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.1550	3.9	5.1
392	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7173	2.8	3.4
393	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6593	4.9	6.8
394	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9939	3.7	4.7
395	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6749	2.5	3.1
405	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.5743	12.0	15.8
406	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7791	6.5	8.4
407	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8665	4.2	5.2
408	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.9368	11.0	13.5
409	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.4875	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	1.6114	4.9	5.8
411	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.6818	9.9	11.8
412	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.4912	7.0	8.3
413	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.7180	4.5	5.4
414	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6675	9.3	11.4
415	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0897	6.2	7.3
416	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3080	3.7	4.4
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.5029	6.2	7.8

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6996	4.4	5.4
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1698	2.4	3.0
420	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.6443	9.2	13.0
421	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.8910	5.1	7.0
422	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.2742	3.0	4.1
423	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.4577	10.9	14.4
424	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.4335	7.1	9.1
425	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.6273	4.4	5.7
432	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.7001	5.0	6.5
433	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9548	3.6	4.6
434	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6152	2.5	3.2
435	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.8018	5.6	7.4
436	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.2215	4.2	5.5
437	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.9004	2.8	3.7
438	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.8342	5.4	7.5
439	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	1.0089	4.0	5.0
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6890	2.9	3.5
441	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8242	5.1	7.1
442	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9857	3.7	4.8
443	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6615	2.7	3.3
444	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.5586	4.8	6.2
445	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0688	3.6	4.5
446	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7411	2.5	3.1
453	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.2653	10.7	13.5
454	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.2559	5.5	6.7
455	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.4308	3.1	3.7
456	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	9.2885	10.8	13.4
457	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.2024	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	4.9379	3.5	4.0
459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.5065	7.4	9.1
460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.8713	3.3	3.9
461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9385	6.7	8.2
462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3425	3.7	4.1
463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	4.9983	11.0	15.1
464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8528	6.9	8.9

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7905	4.1	5.3
466	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.9144	7.3	9.0
467	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.2321	4.3	5.0
468	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5728	3.3	3.6
469	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.4724	6.7	8.0
470	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.1039	3.4	3.7
471	No	No	08	SURG	CERVICAL SPINAL FUSION W MCC	4.7301	6.6	9.3
472	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.7722	2.6	3.8
473	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0768	1.5	1.8
474	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.4905	9.1	11.9
475	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9594	6.1	7.7
476	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	0.9920	3.2	4.1
477	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.3286	8.9	11.1
478	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2546	5.3	6.8
479	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.6367	2.4	3.4
480	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0939	7.7	9.0
481	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.8886	5.1	5.6
482	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5372	4.1	4.5
483	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.4019	3.0	3.7
484	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.9554	2.0	2.2
485	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.2131	9.0	11.0
486	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0339	6.1	7.2
487	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4724	4.4	5.1
488	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.7217	3.8	4.7
489	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2141	2.5	2.9
490	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7916	3.0	4.3
491	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	0.9914	1.7	2.1
492	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.0670	6.8	8.6
493	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	1.8519	4.2	5.0
494	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.3140	2.7	3.2
495	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8683	7.6	10.2
496	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6207	4.1	5.4
497	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0770	2.0	2.6
498	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9912	5.4	7.3
499	No	No	08	SURG	LOCAL EXCISION & REMOVAL	0.9917	2.2	3.0

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC			
500	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0288	7.6	10.3
501	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5846	4.6	6.0
502	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.0305	2.3	2.8
503	No	No	08	SURG	FOOT PROCEDURES W MCC	2.2809	6.5	8.5
504	No	No	08	SURG	FOOT PROCEDURES W CC	1.5685	5.0	6.2
505	No	No	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.0770	2.5	3.1
506	No	No	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1815	2.7	3.8
507	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.8711	3.4	4.5
508	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.3956	1.7	2.1
509	No	No	08	SURG	ARTHROSCOPY	1.3148	2.3	3.5
510	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.1704	5.0	6.3
511	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.4690	3.2	3.9
512	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0461	1.8	2.1
513	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.3007	3.5	4.8
514	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.8209	2.1	2.7
515	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.1894	7.7	9.8
516	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9244	4.7	5.9
517	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.4797	2.6	3.4
533	Yes	No	08	MED	FRACTURES OF FEMUR W MCC	1.5657	4.9	6.5
534	Yes	No	08	MED	FRACTURES OF FEMUR W/O MCC	0.7601	3.1	3.9
535	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.3527	4.5	5.8
536	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7191	3.2	3.7
537	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8275	3.5	4.1
538	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.6108	2.6	3.1
539	Yes	No	08	MED	OSTEOMYELITIS W MCC	2.0467	7.1	9.4
540	Yes	No	08	MED	OSTEOMYELITIS W CC	1.3126	5.4	6.8
541	Yes	No	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8713	3.7	4.7
542	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.9521	6.3	8.3
543	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1597	4.5	5.6
544	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7775	3.4	4.1
545	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.5467	6.4	9.0
546	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1712	4.2	5.4
547	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7348	2.9	3.6
548	No	No	08	MED	SEPTIC ARTHRITIS W MCC	1.9648	6.7	8.8
549	No	No	08	MED	SEPTIC ARTHRITIS W CC	1.2035	4.8	6.1
550	No	No	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.8276	3.3	4.0
551	Yes	No	08	MED	MEDICAL BACK PROBLEMS W MCC	1.6398	5.2	6.8
552	Yes	No	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.8204	3.3	4.0
553	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.1355	4.3	5.5
554	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6812	3.0	3.7
555	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.0954	3.6	4.9

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
556	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6568	2.6	3.2
557	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.6021	5.4	6.8
558	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8823	3.6	4.4
559	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7717	5.2	7.2
560	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0022	3.6	4.6
561	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.6211	2.1	2.6
562	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3944	4.5	5.8
563	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.7153	3.0	3.6
564	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4702	4.9	6.5
565	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9095	3.8	4.7
566	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6625	2.8	3.4
573	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	3.2461	9.1	12.5
574	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.8675	6.7	8.5
575	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.0899	4.2	5.2
576	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.9248	9.1	13.0
577	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	1.7035	4.1	6.2
578	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0416	2.4	3.3
579	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.9576	7.7	10.4
580	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4959	3.8	5.4
581	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.9223	1.8	2.4
582	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.0567	2.0	2.7
583	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.8454	1.5	1.7
584	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.5153	3.5	5.0
585	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.0411	1.7	2.2
592	Yes	No	09	MED	SKIN ULCERS W MCC	1.7669	6.2	8.2
593	Yes	No	09	MED	SKIN ULCERS W CC	1.0709	4.8	5.8
594	Yes	No	09	MED	SKIN ULCERS W/O CC/MCC	0.7591	3.6	4.6
595	No	No	09	MED	MAJOR SKIN DISORDERS W MCC	1.8690	5.9	7.8
596	No	No	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8779	3.7	4.6
597	No	No	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.5596	5.5	7.5
598	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0611	4.1	5.4
599	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6265	2.5	3.2
600	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9602	4.1	4.9
601	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6728	3.0	3.6
602	Yes	No	09	MED	CELLULITIS W MCC	1.4748	5.3	6.7
603	Yes	No	09	MED	CELLULITIS W/O MCC	0.8377	3.8	4.5
604	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.2361	3.9	5.2
605	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.7182	2.7	3.3
606	No	No	09	MED	MINOR SKIN DISORDERS W MCC	1.3082	4.3	6.0

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
607	No	No	09	MED	MINOR SKIN DISORDERS W/O MCC	0.6857	2.8	3.7
614	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.4554	4.7	6.5
615	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.3970	2.5	3.0
616	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.4934	12.4	15.6
617	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0006	6.5	7.9
618	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.2006	4.1	5.1
619	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.5214	4.6	7.4
620	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8627	2.6	3.4
621	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4747	1.6	1.9
622	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.4166	9.4	12.5
623	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8558	6.1	7.6
624	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.0122	3.8	4.7
625	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2423	4.6	6.9
626	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1701	2.1	3.0
627	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.7821	1.2	1.4
628	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.3819	7.2	10.6
629	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.2650	6.5	8.0
630	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.4164	3.4	4.5
637	Yes	No	10	MED	DIABETES W MCC	1.4462	4.5	5.9
638	Yes	No	10	MED	DIABETES W CC	0.8306	3.2	4.0
639	Yes	No	10	MED	DIABETES W/O CC/MCC	0.5544	2.3	2.8
640	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	1.1400	3.6	5.1
641	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	0.6916	2.9	3.6
642	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0290	3.4	4.7
643	Yes	No	10	MED	ENDOCRINE DISORDERS W MCC	1.8159	6.0	7.6
644	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0655	4.2	5.2
645	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7198	2.9	3.6
652	No	No	11	SURG	KIDNEY TRANSPLANT	3.0442	6.3	7.4
653	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W MCC	6.0929	13.6	16.6
654	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W CC	3.0054	8.2	9.3
655	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9567	4.8	5.6
656	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.5713	7.7	10.0
657	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	2.0004	4.9	5.9
658	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.4224	3.0	3.4
659	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.4988	7.9	10.8
660	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.9030	4.5	6.0
661	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2641	2.4	2.9
662	No	No	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.0158	7.5	10.7
663	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4718	3.6	5.2

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
664	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1074	1.5	1.9
665	No	No	11	SURG	PROSTATECTOMY W MCC	2.8653	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	0.7919	1.8	2.4
668	No	No	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.5175	6.6	8.9
669	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2597	3.2	4.4
670	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7770	1.8	2.3
671	No	No	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.4400	4.1	5.6
672	No	No	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.7885	1.8	2.2
673	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9260	5.9	9.5
674	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.0934	4.6	6.7
675	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3379	1.6	2.1
682	Yes	No	11	MED	RENAL FAILURE W MCC	1.6407	5.1	6.8
683	Yes	No	11	MED	RENAL FAILURE W CC	1.0243	4.0	4.9
684	Yes	No	11	MED	RENAL FAILURE W/O CC/MCC	0.6587	2.8	3.4
685	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8944	2.5	3.4
686	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.8238	5.8	7.8
687	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0838	3.8	5.0
688	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6479	2.2	2.8
689	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.2185	4.6	5.8
690	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7864	3.4	4.1
691	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6156	3.3	4.3
692	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1186	1.8	2.3
693	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3505	3.9	5.2
694	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7096	2.1	2.6
695	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2082	4.3	5.7
696	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6590	2.6	3.2
697	No	No	11	MED	URETHRAL STRICTURE	0.7771	2.4	3.1
698	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6098	5.2	6.8
699	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9999	3.7	4.7
700	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6757	2.6	3.2
707	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7747	3.2	4.2
708	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2581	1.6	1.9
709	No	No	12	SURG	PENIS PROCEDURES W CC/MCC	1.8630	3.4	5.7
710	No	No	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.2712	1.4	1.7
711	No	No	12	SURG	TESTES PROCEDURES W CC/MCC	1.7639	5.2	7.3
712	No	No	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.8084	2.1	2.7
713	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.1802	2.9	4.1
714	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.6544	1.6	1.8
715	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7433	4.1	6.0
716	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0.9974	1.2	1.4
717	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6138	4.6	6.4
718	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.8044	2.0	2.6
722	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6891	5.4	7.7
723	No	No	12	MED	MALIGNANCY, MALE	1.0190	3.9	5.1

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					REPRODUCTIVE SYSTEM W CC			
724	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6211	2.1	2.7
725	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2742	4.7	6.1
726	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7013	2.8	3.5
727	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3657	4.9	6.4
728	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7612	3.3	4.1
729	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.9892	3.6	4.7
730	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6414	2.3	2.9
734	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.4364	5.2	7.0
735	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.1684	2.2	2.7
736	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.3943	11.5	14.0
737	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0375	5.7	6.6
738	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.2324	3.2	3.6
739	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.4300	7.4	9.8
740	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5280	3.8	4.7
741	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.0979	2.2	2.6
742	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3883	3.2	4.1
743	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.9079	1.8	2.1
744	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.5151	4.0	5.5
745	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.8045	2.0	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	0.8852	1.5	1.8
748	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9169	1.4	1.7
749	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5275	6.2	8.5
750	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0.9368	2.2	2.8
754	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	2.0295	6.4	8.8
755	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1444	4.0	5.3
756	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6361	2.3	3.1
757	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.6565	6.0	7.8
758	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0963	4.7	5.7
759	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7368	3.3	4.0
760	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8388	2.9	3.8
761	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5219	1.8	2.2
765	No	No	14	SURG	CESAREAN SECTION W CC/MCC	1.1269	3.9	4.9

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
766	No	No	14	SURG	CESAREAN SECTION W/O CC/MCC	0.7995	2.9	3.1
767	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.9111	2.4	2.7
768	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.8112	4.7	5.8
769	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2.0631	3.5	5.7
770	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7017	1.6	2.1
774	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6848	2.6	3.2
775	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5256	2.1	2.3
776	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6513	2.6	3.4
777	No	No	14	MED	ECTOPIC PREGNANCY	0.7406	1.7	2.1
778	No	No	14	MED	THREATENED ABORTION	0.4942	2.1	3.2
779	No	No	14	MED	ABORTION W/O D&C	0.5311	1.6	2.1
780	No	No	14	MED	FALSE LABOR	0.2284	1.2	1.6
781	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6809	2.7	3.9
782	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4744	1.9	2.6
789	No	No	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4877	1.8	1.8
790	No	No	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.9058	17.9	17.9
791	No	No	15	MED	PREMATURITY W MAJOR PROBLEMS	3.3505	13.3	13.3
792	No	No	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.0216	8.6	8.6
793	No	No	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.4417	4.7	4.7
794	No	No	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.2181	3.4	3.4
795	No	No	15	MED	NORMAL NEWBORN	0.1649	3.1	3.1
799	No	No	16	SURG	SPLENECTOMY W MCC	4.9434	10.4	13.5
800	No	No	16	SURG	SPLENECTOMY W CC	2.5874	5.9	7.5
801	No	No	16	SURG	SPLENECTOMY W/O CC/MCC	1.5586	3.1	3.9
802	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.6171	8.5	12.1
803	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.8905	4.8	6.5
804	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0446	2.3	3.0
808	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1479	6.3	8.2
809	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1951	4.0	5.1
810	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9230	3.0	3.7
811	No	No	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2544	3.8	5.2
812	No	No	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.7957	2.8	3.6
813	No	No	16	MED	COAGULATION DISORDERS	1.4372	3.6	5.0
814	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6431	5.0	6.9
815	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.0024	3.6	4.6
816	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6818	2.6	3.2
820	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.7112	13.1	17.2
821	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3998	5.3	7.4
822	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2253	2.3	3.1
823	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	4.5640	12.2	15.9
824	No	No	17	SURG	LYMPHOMA & NON-ACUTE	2.3055	6.6	8.7

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					LEUKEMIA W OTHER O.R. PROC W CC			
825	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2418	2.8	4.0
826	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.8666	11.2	14.7
827	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.1459	5.3	6.9
828	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.3861	3.1	3.8
829	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.7093	6.3	9.4
830	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	1.0976	2.4	3.2
834	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	4.9277	10.1	16.2
835	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.4284	5.7	9.2
836	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.1386	3.0	4.5
837	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.6599	17.8	23.5
838	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.1428	8.1	12.2
839	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2823	4.6	5.7
840	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	2.9317	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	1.0389	3.2	4.2
843	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8363	6.0	8.0
844	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1940	4.3	5.6
845	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8029	2.9	3.7
846	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.1961	5.4	8.0
847	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	0.9860	2.8	3.4
848	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.8078	2.4	3.0
849	No	No	17	MED	RADIOTHERAPY	1.2627	4.4	6.1
853	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.5237	12.0	15.6
854	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.7883	8.2	10.0
855	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.3797	3.9	5.3
856	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	5.1296	11.2	15.0
857	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0975	6.2	7.9
858	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3050	4.1	5.1
862	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.9511	5.8	7.7
863	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9790	4.0	4.9
864	No	No	18	MED	FEVER	0.8276	3.0	3.8
865	No	No	18	MED	VIRAL ILLNESS W MCC	1.5651	4.5	6.5
866	No	No	18	MED	VIRAL ILLNESS W/O MCC	0.7462	2.8	3.5
867	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.4708	6.7	9.2
868	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES	1.1614	4.3	5.4

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					DIAGNOSES W CC			
869	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7207	3.0	3.6
870	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8305	12.8	15.1
871	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.9074	5.4	7.2
872	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1545	4.5	5.4
876	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.8143	8.1	12.7
880	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6161	2.3	3.0
881	No	No	19	MED	DEPRESSIVE NEUROSES	0.6178	3.1	4.2
882	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6276	3.1	4.3
883	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.0694	4.9	7.7
884	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9308	4.0	5.3
885	No	No	19	MED	PSYCHOSES	0.9041	5.4	7.4
886	No	No	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.7903	3.8	5.9
887	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.7888	2.9	4.1
894	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4074	2.1	3.0
895	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.0275	8.5	10.9
896	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.4565	4.7	6.5
897	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6513	3.2	4.0
901	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	3.9042	9.1	14.0
902	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7922	5.4	7.5
903	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0624	3.3	4.4
904	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	2.9335	7.2	10.9
905	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.1714	3.4	4.5
906	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	1.0356	2.1	3.1
907	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8268	7.8	11.1
908	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9251	4.7	6.3
909	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1554	2.6	3.4
913	No	No	21	MED	TRAUMATIC INJURY W MCC	1.3444	4.0	5.6
914	No	No	21	MED	TRAUMATIC INJURY W/O MCC	0.6994	2.6	3.2
915	No	No	21	MED	ALLERGIC REACTIONS W MCC	1.4252	3.6	5.1
916	No	No	21	MED	ALLERGIC REACTIONS W/O MCC	0.4867	1.7	2.1
917	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4868	3.7	5.1
918	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.6269	2.1	2.7
919	No	No	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.5903	4.4	6.2
920	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9785	3.2	4.3
921	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6216	2.2	2.8
922	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.3478	3.8	5.4
923	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6808	2.3	3.2
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.6651	21.8	28.5
928	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.7724	10.8	14.8
929	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.0557	5.2	7.7
933	No	No	22	MED	EXTENSIVE BURNS OR FULL	2.1979	2.3	5.1

MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
					THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT			
934	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3556	4.1	5.8
935	No	No	22	MED	NON-EXTENSIVE BURNS	1.2919	3.5	5.2
939	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	2.8702	6.9	10.0
940	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.6797	3.6	5.4
941	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1457	2.0	2.6
945	Yes	No	23	MED	REHABILITATION W CC/MCC	1.2795	8.2	10.1
946	Yes	No	23	MED	REHABILITATION W/O CC/MCC	1.1273	6.6	7.5
947	Yes	No	23	MED	SIGNS & SYMPTOMS W MCC	1.0952	3.7	4.9
948	Yes	No	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6865	2.7	3.4
949	No	No	23	MED	AFTERCARE W CC/MCC	1.0006	2.6	4.4
950	No	No	23	MED	AFTERCARE W/O CC/MCC	0.5040	2.2	2.8
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.6593	2.2	4.0
955	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5336	8.9	12.6
956	Yes	No	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.3704	7.0	8.5
957	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.2519	10.1	14.2
958	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.7692	7.5	9.6
959	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.3208	4.7	5.9
963	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.8123	6.0	8.7
964	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4901	4.5	5.6
965	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9386	3.1	3.8
969	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5073	12.0	17.1
970	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.6755	6.3	8.6
974	No	No	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.5849	6.8	9.6
975	No	No	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3640	5.1	6.6
976	No	No	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.8975	3.5	4.4
977	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0486	3.7	4.9
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0634	11.0	14.1
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.9402	6.8	8.7
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.7767	3.1	4.3
984	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3242	10.5	13.3
985	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.1508	6.8	9.0
986	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1140	2.7	4.0
987	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.4495	9.3	12.1
988	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.8739	5.6	7.4
989	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0589	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
237.79*	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	CC	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
315.35*	Childhood onset fluency disorder	N	01	091,092,093
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
488.01*	Influenza due to identified avian influenza virus with pneumonia	MCC	04 15 25	193,194,195 791[1],793[1] 974,975,976
488.02*	Influenza due to identified avian influenza virus with other respiratory manifestations	CC	04 15	193,194,195 791[1],793[1]
488.09*	Influenza due to identified avian influenza virus with other manifestations	CC	18	865,866
488.11*	Influenza due to identified novel H1N1 influenza virus with pneumonia	MCC	04 15 25	193,194,195 791[1],793[1] 974,975,976
488.12*	Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations	N	04 15	193,194,195 791[1],793[1]
488.19*	Influenza due to identified novel H1N1 influenza virus with other manifestations	N	18	865,866
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
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	CC	01	100,101
780.66	Febrile nonhemolytic transfusion reaction	N	18 25	864 977
784.52*	Fluency disorder in conditions classified elsewhere	N	01	091,092,093
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
799.51	Attention or concentration deficit	N	19	886

Diagnosis Code	Description	CC	MDC	MS-DRG
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, incompatibility 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
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)	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
	congenital malformations of respiratory system			
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 systems	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
V49.87*	Physical restraints 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	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
	material			
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

Diagnosis Code	Description	CC	MDC	MS-DRG
V91.99	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951

Notes:
* These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2010. Please note that new code 237.78, Other neurofibromatosis, that was listed as a new diagnosis code in the proposed rule has been modified to new code 237.79. New code 799.50, Unspecified signs and symptoms involving cognition, that was listed in the proposed rule as a new code has been deleted and will not be implemented on October 1, 2010.
** The CC classification was changed from a non-CC that was listed in the proposed rule to a CC for the final rule.
***The code title has changed from the proposed rule.
[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		
01.20*	Cranial implantation or replacement of neurostimulator pulse generator	Y	01	023[1],024[1],040,041,042
01.29*	Removal of cranial neurostimulator pulse generator	Y	01	040,041,042
17.71*	Non-coronary intra-operative fluorescence vascular angiography [IFVA]	N		
32.27	Bronchoscopic bronchial thermoplasty, ablation of airway smooth muscle	Y	04	163,164,165
35.97*	Percutaneous mitral valve repair with implant	Y	05	231,232,246,247,248, 249,250,251
37.37*	Excision or destruction of other lesion or tissue of heart, thoracoscopic approach	Y	05	228,229,230
38.97*	Central venous catheter placement with guidance	N		
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
84.94*	Insertion of sternal fixation device with rigid plates	Y	04 05 08 21 24	166,167,168 264 515,516,517 907,908,909 957,958,959
85.55*	Fat graft to breast	Y	09	584,585
86.87*	Fat graft of skin and subcutaneous tissue	Y	03 09 10 21 24	133,134 579,580,581 619,620,621 907,908,909 957,958,959
86.90*	Extraction of fat for graft or banking	Y	09	579,580,581

Notes:
* These procedure codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2011 IPPS/LTCH PSS proposed rule. However, they will be implemented on October 1, 2010.
[1] Assigned to MS-DRG 023/024 when both 01.20 and 02.93 are reported.

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
488.0*	Influenza due to identified avian influenza virus	N	03	152,153
488.1*	Influenza due to identified novel H1N1 influenza virus	N	03	152,153
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:

* These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be deleted on October 1, 2010.

[1] Secondary diagnosis of major problem

TABLE 6D.—INVALID DIAGNOSIS 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
307.0*	Adult onset fluency disorder	N	19	887
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
V07.51*	Use of selective estrogen receptor modulators (SERMs)	N	23	951
V07.52*	Use of aromatase inhibitors	N	23	951
V07.59*	Use of other agents affecting estrogen receptors and estrogen levels	N	23	951
V07.8*	Other specified prophylactic or treatment measure	N	23	951
V07.9*	Unspecified prophylactic or treatment measure	N	23	951
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

Notes:

* These diagnosis codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2010.

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		
35.96*	Percutaneous balloon valvuloplasty	Y	05	231,232,246,247,248, 249,250,251
37.34*	Excision or destruction of other lesion or tissue of heart, endovascular approach	Y	05	246,247,248,249,250, 251
81.02*	Other cervical fusion of the anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,471,472, 473 907,908,909 957,958,959
81.03*	Other cervical fusion of the posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,471,472, 473 907,908,909 957,958,959
81.04*	Dorsal and dorsolumbar fusion of the anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.05*	Dorsal and dorsolumbar fusion of the posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.06*	Lumbar and lumbosacral fusion of the anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.07*	Lumbar and lumbosacral fusion of the posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.08*	Lumbar and lumbosacral fusion of the anterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.32*	Refusion of other cervical spine, anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,471,472, 473 907,908,909 957,958,959
81.33*	Refusion of other cervical spine, posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,471,472, 473 907,908,909 957,958,959
81.34*	Refusion of dorsal and dorsolumbar spine, anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.35*	Refusion of dorsal and dorsolumbar spine, posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959

Procedure Code	Description	O.R.	MDC	MS-DRG
81.36*	Refusion of lumbar and lumbosacral spine, anterior column, anterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.37*	Refusion of lumbar and lumbosacral spine, posterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.38*	Refusion of lumbar and lumbosacral spine, anterior column, posterior technique	Y	01 08 21 24	028,029,030 453,454,455,456,457, 458,459,460 907,908,909 957,958,959
81.80	Other total shoulder replacement	Y	08 21 24	483,484 907,908,909 957,958,959
83.21*	Open biopsy of soft tissue	Y	01 04 08 09 16	040,041,042 166,167,168 500,501,502 579,580,581 802,803,804
86.11*	Closed biopsy of skin and subcutaneous tissue	N		
88.59*	Intra-operative coronary fluorescence vascular angiography	N		
99.14	Injection or infusion of immunoglobulin	N		

Notes:

* These procedure codes were discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2011 IPPS/LTCH PPS proposed rule. However, they will be implemented on October 1, 2010.

TABLE 7A.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2009 MEDPAR UPDATE - MARCH 2010 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
58	1,005	7.0537	2	3	5	8	13
59	3,138	4.9143	2	3	4	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
178	60,900	6.6817	3	4	6	8	12
179	16,039	4.9675	2	3	4	6	9
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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 LENGTHS OF STAY: FY 2009 MEDPAR UPDATE - MARCH 2010 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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
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
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—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—JULY 2010

State	Urban	Rural
Alabama	0.25	0.317
Alaska	0.342	0.628
Arizona	0.264	0.35
Arkansas	0.306	0.326
California	0.213	0.271
Colorado	0.272	0.402
Connecticut	0.389	0.517
Delaware	0.479	0.409
District of Columbia*	0.324	----
Florida	0.22	0.236
Georgia	0.307	0.369
Hawaii	0.379	0.48
Idaho	0.44	0.546
Illinois	0.289	0.362
Indiana	0.366	0.432
Iowa	0.333	0.407
Kansas	0.279	0.405
Kentucky	0.359	0.35
Louisiana	0.292	0.329
Maine	0.48	0.45
Maryland	0.709	0.756
Massachusetts	0.468	0.977
Michigan	0.368	0.435
Minnesota	0.382	0.507
Mississippi	0.283	0.336
Missouri	0.315	0.341

Montana	0.402	0.458
Nebraska	0.331	0.432
Nevada	0.196	0.42
New Hampshire	0.428	0.42
New Jersey*	0.175	----
New Mexico	0.328	0.365
New York	0.345	0.51
North Carolina	0.37	0.379
North Dakota	0.423	0.383
Ohio	0.317	0.481
Oklahoma	0.285	0.37
Oregon	0.425	0.39
Pennsylvania	0.25	0.401
Puerto Rico*	0.489	----
Rhode Island*	0.373	----
South Carolina	0.273	0.304
South Dakota	0.311	0.387
Tennessee	0.278	0.336
Texas	0.244	0.325
Utah	0.395	0.598
Vermont	0.558	0.632
Virginia	0.341	0.348
Washington	0.34	0.445
West Virginia	0.436	0.464
Wisconsin	0.394	0.443
Wyoming	0.387	0.517

*All counties in the State or Territory are classified as urban.

TABLE 8B—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—JULY 2010

State	Ratio
Alabama	0.024
Alaska	0.039
Arizona	0.027
Arkansas	0.024
California	0.014
Colorado	0.03
Connecticut	0.026
Delaware	0.037
District of Columbia	0.02
Florida	0.022
Georgia	0.027
Hawaii	0.028
Idaho	0.038
Illinois	0.025
Indiana	0.036
Iowa	0.029
Kansas	0.03
Kentucky	0.031
Louisiana	0.025
Maine	0.031
Maryland	0.064

State	Ratio
Massachusetts	0.033
Michigan	0.031
Minnesota	0.031
Mississippi	0.026
Missouri	0.028
Montana	0.033
Nebraska	0.039
Nevada	0.022
New Hampshire	0.035
New Jersey	0.013
New Mexico	0.033
New York	0.026
North Carolina	0.031
North Dakota	0.033
Ohio	0.029
Oklahoma	0.027
Oregon	0.04
Pennsylvania	0.021
Puerto Rico	0.04
Rhode Island	0.02
South Carolina	0.025
South Dakota	0.027
Tennessee	0.026
Texas	0.026
Utah	0.036
Vermont	0.045
Virginia	0.034
Washington	0.029
West Virginia	0.032
Wisconsin	0.036
Wyoming	0.04

TABLE 8C.—STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS (CCRs) FOR LTCHs—JULY 2010

State	Urban	Rural
Alabama	0.272	0.349
Alaska	0.373	0.721
Arizona	0.291	0.384
Arkansas	0.328	0.356
California	0.227	0.292
Colorado	0.3	0.449
Connecticut	0.414	0.566
Delaware	0.516	0.447
District of Columbia*	0.344	----
Florida	0.24	0.278
Georgia	0.331	0.412
Hawaii	0.404	0.502
Idaho	0.478	0.585
Illinois	0.313	0.391
Indiana	0.399	0.484
Iowa	0.362	0.444
Kansas	0.306	0.449
Kentucky	0.389	0.383
Louisiana	0.316	0.351
Maine	0.511	0.483
Maryland**	0.325	0.416
Massachusetts	0.498	1.076
Michigan	0.399	0.468
Minnesota	0.412	0.552
Mississippi	0.309	0.364
Missouri	0.34	0.373
Montana	0.431	0.5
Nebraska	0.368	0.475
Nevada	0.217	0.481
New Hampshire	0.463	0.449
New Jersey*	0.189	----
New Mexico	0.36	0.4
New York	0.368	0.545
North Carolina	0.401	0.407
North Dakota	0.445	0.423
Ohio	0.343	0.523
Oklahoma	0.295	0.403
Oregon	0.465	0.425

State	Urban	Rural
Pennsylvania	0.267	0.434
Puerto Rico*	0.527	----
Rhode Island*	0.393	----
South Carolina	0.298	0.325
South Dakota	0.335	0.421
Tennessee	0.301	0.373
Texas	0.268	0.363
Utah	0.431	0.651
Vermont	0.608	0.67
Virginia	0.375	0.379
Washington	0.371	0.476
West Virginia	0.463	0.498
Wisconsin	0.421	0.482
Wyoming	0.424	0.562

*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	26620	
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	37860	
010085	19460	26620	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	13820	
010126	01	33860	
010143	01	26620	
010158	01	22520	
010164	01	13820	
020008	02	11260	
030033	03	22380	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	22220	
040020	27860	32820	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	26	
040071	38220	30780	
040076	04	26300	LUGAR
040080	04	27860	
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	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050075	36084	41940	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050084	44700	40900	
050089	40140	31084	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050125	41940	42100	
050129	40140	31084	
050131	41884	36084	
050140	40140	31084	
050150	05	40900	
050152	41884	36084	
050153	41940	42100	
050168	42044	31084	
050173	42044	31084	
050188	41940	42100	
050193	42044	31084	
050195	36084	41940	
050197	41884	41940	
050211	36084	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050243	40140	42044	
050245	40140	31084	
050264	36084	41940	
050272	40140	31084	
050279	40140	31084	
050283	36084	41940	
050292	40140	42044	
050300	40140	31084	
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	
050390	40140	42044	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050488	36084	41940	
050510	41884	36084	
050512	36084	41940	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050548	42044	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	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	
050693	42044	31084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050748	44700	33700	
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	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	LUGAR
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
100002	48424	22744	
100014	19660	36740	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100290	10	36740	
100292	10	18880	LUGAR
110001	19140	16860	
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	46660	
110040	11	12060	LUGAR
110041	11	12020	
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	12060	
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	
140062	16974	29404	
140063	16974	29404	
140064	14	37900	
140065	16974	29404	
140068	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	
140158	16974	29404	
140160	14	40420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
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	
150018	21140	43780	
150023	45460	26900	
150026	21140	43780	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	14020	
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	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	14540	
180018	18	30460	
180020	18	49	
180024	18	31140	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	
180048	18	31140	
180049	18	30460	
180069	18	26580	
180078	18	26580	
180080	18	28940	
180093	18	21780	
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	10780	
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	
220008	39300	14484	
220010	37764	14484	
220019	49340	14484	
220020	39300	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220058	49340	14484	
220062	49340	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220090	49340	14484	
220095	49340	14484	
220163	49340	14484	
220174	37764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	22420	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	
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	22420	
230297	19804	11460	
230301	47644	22420	
230302	47644	22420	
230B04	47644	22420	
230B95	19804	11460	
240069	24	33460	
240071	24	33460	
240075	24	41060	
240088	24	41060	
240093	31860	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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
260022	26	16	
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	
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	
300001	30	31700	
300011	31700	15764	
300012	31700	15764	
300017	40484	37764	
300019	30	15764	
300020	31700	15764	
300029	40484	37764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
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	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	35644	
330027	35004	35644	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
340023	11700	24860	
340027	34	24780	
340037	34	16740	
340039	34	49180	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340071	34	39580	LUGAR
340085	34	24660	LUGAR
340091	24660	49180	
340096	34	24660	LUGAR
340109	34	47260	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
350006	35	13900	
360008	36	26580	
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	31900	
360054	36	26580	
360055	49660	17460	
360065	36	45780	
360078	10420	17460	
360086	44220	19380	
360095	36	30620	
360109	36	18140	
360112	45780	33780	
360121	36	45780	
360133	19380	17140	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360211	44600	38300	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
370026	37	36420	
370030	37	46140	
370047	37	36420	
370049	37	36420	
370099	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	38300	
390030	39	10900	
390031	39	39740	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390067	25420	29540	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	38300	
390091	39	49660	
390093	39	49660	
390096	39740	37964	
390110	27780	38300	
390113	39	21500	
390133	10900	37964	
390138	39	13644	
390151	39	13644	
390162	10900	35084	
390185	42540	10900	
390313	39	39740	LUGAR
390316	39740	37964	
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420009	42	24860	LUGAR
420020	42	16700	
420027	11340	24860	
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420067	42	42340	
420068	42	12260	
420069	42	44940	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420085	34820	48900	
420101	42	42340	
430012	43	43620	
440002	27180	32820	
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	16860	
440151	44	34980	
440174	44	32820	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
450196	45	19124	
450211	45	30980	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450370	45	26420	
450389	45	19124	LUGAR
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	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	47894	
490042	13980	40220	
490066	47260	40060	
490079	49	49180	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	33340	
520095	52	31540	
520096	39540	33340	
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
530014	16940	24540	

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT--FY 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
230040	24340	23
230078	35660	23
260006	41140	26
260034	28140	26
260047	27620	26
260195	44180	26
300023	40484	30
330215	46540	33
330235	33	33
330268	10580	33
340010	24140	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)—JULY 2010[1]

MS-DRG	Number of Cases	Threshold
1	904	$435,635
2	340	$240,204
3	21,663	$280,811
4	20,995	$171,157
5	890	$180,515
6	411	$107,248
7	463	$179,156
8	519	$111,379
10	141	$88,052
11	1,441	$84,605
12	1,936	$62,428
13	994	$43,962
14	440	$176,208
15	1,360	$111,368
20	1,061	$161,530
21	458	$124,123
22	143	$85,832
23	4,308	$96,440
24	1,684	$70,282
25	11,427	$86,459
26	11,336	$61,693
27	12,456	$49,503
28	1,837	$90,766
29	3,474	$55,153
30	3,387	$35,901
31	1,159	$69,740
32	2,767	$42,792
33	3,323	$35,379
34	797	$71,883
35	2,295	$51,044
36	5,681	$43,530
37	4,866	$61,993
38	14,284	$39,306
39	43,343	$29,220
40	4,759	$69,298
41	7,481	$45,993
42	3,756	$39,362
52	1,234	$35,065
53	487	$24,276
54	7,112	$33,757
55	12,871	$29,346
56	9,195	$33,767
57	42,593	$22,987
58	879	$33,311
59	3,210	$26,504
60	3,493	$20,860
61	2,243	$63,283
62	3,708	$49,293
63	1,296	$43,014
64	60,333	$39,150
65	111,548	$31,479
66	65,887	$23,719
67	1,368	$35,053
68	10,268	$26,625
69	91,552	$21,734
70	9,551	$38,428
71	13,615	$29,872
72	4,768	$21,702
73	8,645	$30,813
74	31,104	$24,192
75	1,334	$38,649
76	653	$26,799
77	1,511	$38,492
78	2,104	$28,951
79	762	$21,909
80	1,606	$29,704
81	5,808	$20,751
82	2,368	$40,089
83	2,570	$32,677
84	2,513	$25,230
85	7,254	$40,724
86	14,210	$30,382
87	12,897	$21,689
88	871	$35,364
89	3,139	$27,447
90	2,469	$20,661
91	8,634	$34,687
92	19,466	$25,192
93	12,991	$19,432
94	1,411	$65,260
95	1,173	$49,584
96	536	$42,821

MS-DRG	Number of Cases	Threshold
97	1,171	$61,087
98	1,055	$42,314
99	420	$32,915
100	19,048	$33,596
101	55,537	$21,439
102	1,277	$27,872
103	12,383	$20,097
113	636	$40,536
114	421	$25,642
115	839	$31,969
116	449	$31,818
117	526	$20,914
121	739	$23,689
122	518	$16,009
123	2,643	$21,908
124	727	$28,858
125	4,222	$18,972
129	1,492	$48,926
130	938	$34,803
131	1,113	$46,489
132	728	$33,577
133	2,215	$37,004
134	2,562	$24,428
135	461	$43,098
136	347	$28,306
137	873	$31,645
138	723	$22,439
139	1,358	$25,412
146	731	$41,806
147	1,353	$29,662
148	545	$22,876
149	33,079	$18,779
150	1,156	$29,162
151	6,113	$15,996
152	2,272	$25,711
153	11,347	$17,556
154	2,426	$32,467
155	6,106	$24,853
156	3,463	$17,496
157	1,355	$33,880
158	3,645	$24,539
159	1,417	$16,307
163	13,290	$92,306
164	18,678	$56,585
165	10,453	$43,781
166	22,840	$67,955
167	19,601	$46,202
168	4,336	$35,003
175	13,969	$38,306
176	36,405	$28,956
177	67,576	$42,148
178	71,373	$34,249
179	15,948	$25,900
180	20,404	$38,784
181	25,881	$31,195
182	2,799	$23,749
183	2,661	$35,325
184	5,206	$26,650
185	2,215	$18,915
186	10,609	$35,940
187	10,847	$29,689
188	3,266	$21,532
189	93,310	$32,084
190	135,970	$30,789
191	149,154	$26,319
192	133,298	$19,680
193	103,191	$34,806
194	205,819	$27,274
195	86,409	$19,336
196	6,888	$36,124
197	6,728	$29,716
198	3,015	$22,578
199	3,778	$38,785
200	8,640	$27,742
201	2,735	$19,045
202	38,501	$23,001
203	28,734	$16,689
204	23,026	$19,871
205	6,565	$30,886
206	19,762	$21,499
207	35,517	$96,595
208	74,036	$48,661
215	176	$195,119
216	9,453	$182,150
217	6,860	$133,308
218	1,213	$112,360

MS-DRG	Number of Cases	Threshold
219	12,653	$149,036
220	16,756	$110,147
221	4,446	$96,266
222	2,728	$166,716
223	3,823	$131,404
224	2,701	$152,227
225	4,447	$125,476
226	7,201	$123,932
227	29,695	$103,887
228	2,292	$142,063
229	2,839	$100,744
230	801	$79,215
231	1,349	$164,923
232	1,212	$131,017
233	15,174	$140,080
234	27,298	$105,954
235	9,403	$111,773
236	25,318	$83,680
237	21,884	$98,303
238	39,819	$66,014
239	10,728	$69,751
240	10,647	$47,566
241	1,554	$34,125
242	17,733	$73,248
243	40,896	$58,638
244	44,299	$48,772
245	3,908	$84,827
246	30,663	$74,531
247	141,780	$54,733
248	14,281	$69,279
249	46,037	$51,182
250	7,591	$64,663
251	36,059	$49,832
252	40,072	$57,736
253	44,232	$53,373
254	37,999	$41,806
255	2,449	$45,842
256	3,180	$35,498
257	388	$25,303
258	755	$59,927
259	4,991	$43,562
260	1,754	$63,568
261	3,876	$37,620
262	2,397	$30,319
263	516	$35,623
264	22,132	$46,546
265	1,693	$47,704
280	69,492	$39,430
281	52,979	$31,725
282	34,664	$24,296
283	12,521	$36,220
284	3,995	$25,802
285	1,421	$17,118
286	24,941	$47,011
287	133,420	$34,891
288	2,631	$53,977
289	1,191	$39,750
290	240	$31,119
291	174,574	$33,653
292	246,130	$26,662
293	116,913	$18,276
294	1,534	$25,868
295	873	$15,614
296	1,891	$31,229
297	750	$20,840
298	365	$13,467
299	21,009	$32,133
300	48,032	$24,806
301	28,537	$16,976
302	7,646	$26,065
303	51,771	$17,024
304	2,830	$28,147
305	32,893	$17,729
306	3,039	$32,018
307	5,966	$21,635
308	56,168	$30,566
309	106,873	$22,931
310	126,820	$16,093
311	15,492	$15,032
312	163,199	$20,531
313	165,304	$17,050
314	60,023	$36,345
315	31,229	$26,015
316	10,548	$17,631
326	11,216	$99,792
327	10,333	$56,018

MS-DRG	Number of Cases	Threshold
328	8,504	$37,077
329	45,684	$93,076
330	59,943	$54,945
331	24,126	$40,765
332	1,596	$86,585
333	5,265	$53,466
334	3,009	$39,217
335	6,973	$80,791
336	13,513	$51,428
337	7,605	$38,145
338	1,272	$66,686
339	2,969	$46,443
340	3,023	$35,071
341	899	$51,098
342	2,900	$37,224
343	6,391	$28,271
344	907	$61,067
345	3,027	$40,265
346	2,577	$30,723
347	1,461	$46,144
348	4,220	$33,975
349	4,010	$22,320
350	1,669	$49,613
351	4,488	$35,435
352	6,384	$24,261
353	3,201	$54,446
354	9,500	$38,710
355	12,844	$27,976
356	7,805	$69,502
357	7,516	$47,068
358	2,036	$35,052
368	3,260	$38,696
369	5,586	$29,640
370	1,753	$21,476
371	22,294	$40,042
372	34,330	$31,153
373	11,091	$22,310
374	7,985	$41,266
375	16,987	$31,506
376	2,500	$24,443
377	47,794	$37,399
378	137,491	$27,242
379	50,326	$19,530
380	2,891	$41,299
381	6,149	$30,728
382	2,677	$23,100
383	1,121	$32,640
384	7,334	$24,966
385	2,180	$39,810
386	8,941	$29,069
387	4,084	$22,157
388	18,488	$35,789
389	54,376	$25,827
390	39,504	$18,179
391	44,495	$29,704
392	245,993	$20,928
393	21,302	$35,214
394	48,508	$27,474
395	19,782	$19,463
405	4,298	$94,331
406	5,063	$57,627
407	1,913	$43,562
408	1,485	$75,778
409	1,442	$53,429
410	470	$39,920
411	781	$74,793
412	830	$57,081
413	521	$44,462
414	4,670	$69,701
415	5,732	$48,029
416	3,964	$35,016
417	17,655	$55,475
418	27,313	$43,931
419	28,075	$34,243
420	704	$68,644
421	897	$43,241
422	232	$34,343
423	1,474	$78,221
424	790	$51,583
425	87	$39,128
432	12,301	$36,553
433	7,990	$26,774
434	395	$17,598
435	12,039	$39,529
436	12,418	$31,263
437	2,148	$27,185

MS-DRG	Number of Cases	Threshold
438	14,775	$38,304
439	27,648	$28,980
440	20,387	$20,523
441	14,277	$36,556
442	18,439	$26,465
443	4,621	$18,647
444	12,517	$36,325
445	18,898	$30,431
446	12,659	$22,482
453	1,125	$182,564
454	3,054	$132,777
455	2,474	$102,493
456	1,115	$164,940
457	3,173	$114,237
458	1,553	$93,076
459	3,808	$113,819
460	61,497	$76,488
461	631	$95,464
462	11,289	$71,111
463	5,226	$72,438
464	8,664	$52,787
465	2,697	$39,971
466	3,674	$86,983
467	20,033	$65,617
468	15,680	$55,286
469	26,919	$67,187
470	410,616	$49,518
471	2,793	$88,790
472	8,549	$59,383
473	24,944	$49,178
474	2,864	$57,945
475	3,755	$40,722
476	1,123	$25,865
477	2,575	$65,129
478	8,828	$51,139
479	5,753	$41,493
480	24,113	$61,905
481	81,197	$45,318
482	33,622	$39,168
483	10,289	$54,649
484	17,897	$47,495
485	1,011	$63,644
486	2,379	$46,983
487	1,055	$38,049
488	3,239	$39,862
489	4,856	$31,847
490	22,741	$41,612
491	44,799	$27,778
492	5,145	$60,728
493	20,357	$44,008
494	25,140	$34,845
495	1,593	$54,433
496	4,846	$38,768
497	5,075	$29,481
498	1,470	$43,345
499	864	$26,453
500	1,827	$54,910
501	5,035	$37,561
502	5,690	$27,635
503	912	$46,419
504	2,796	$37,328
505	2,232	$29,142
506	712	$31,771
507	939	$43,426
508	1,770	$35,622
509	345	$34,644
510	1,046	$48,342
511	4,308	$38,141
512	8,195	$28,861
513	1,240	$33,153
514	916	$22,936
515	3,917	$61,570
516	12,119	$45,028
517	11,032	$37,672
533	818	$32,391
534	3,433	$18,454
535	7,215	$30,771
536	32,600	$17,801
537	933	$21,888
538	692	$16,155
539	3,174	$38,628
540	4,207	$31,102
541	1,110	$22,707
542	5,454	$39,215
543	16,630	$29,623
544	6,541	$20,097

MS-DRG	Number of Cases	Threshold
545	3,551	$42,511
546	6,092	$28,804
547	3,282	$20,114
548	575	$39,440
549	1,206	$29,632
550	549	$20,332
551	10,810	$35,775
552	76,016	$22,258
553	2,115	$28,250
554	17,017	$17,711
555	2,543	$28,015
556	17,245	$18,053
557	3,691	$35,237
558	17,000	$23,531
559	1,886	$34,426
560	5,246	$24,909
561	5,246	$16,050
562	5,811	$31,309
563	32,126	$18,246
564	1,758	$32,697
565	4,008	$24,257
566	1,742	$17,744
573	4,698	$50,276
574	9,923	$37,125
575	3,695	$27,413
576	633	$63,210
577	2,401	$37,738
578	2,506	$28,644
579	3,724	$52,228
580	11,414	$35,450
581	10,603	$26,655
582	4,857	$29,620
583	7,505	$24,145
584	852	$36,843
585	1,411	$29,895
592	3,871	$34,029
593	11,067	$25,239
594	1,460	$17,509
595	1,101	$35,793
596	4,931	$22,365
597	549	$34,856
598	1,502	$28,445
599	185	$18,695

MS-DRG	Number of Cases	Threshold
600	1,021	$24,927
601	777	$17,741
602	22,702	$32,024
603	136,867	$20,982
604	2,629	$30,651
605	19,935	$19,556
606	1,511	$28,631
607	6,970	$17,533
614	1,554	$52,746
615	1,337	$38,408
616	1,619	$73,223
617	6,507	$41,721
618	147	$30,935
619	803	$66,609
620	3,162	$45,048
621	10,932	$39,304
622	1,149	$51,496
623	2,521	$37,581
624	248	$26,730
625	1,198	$47,812
626	2,935	$32,995
627	12,090	$22,786
628	3,400	$60,799
629	4,690	$46,476
630	432	$36,112
637	18,405	$32,205
638	53,628	$21,691
639	24,504	$14,915
640	55,659	$27,820
641	185,651	$18,462
642	1,556	$26,016
643	5,891	$37,738
644	13,464	$28,513
645	6,364	$20,076
652	10,311	$69,265
653	1,683	$103,297
654	3,689	$62,901
655	1,264	$45,991
656	3,192	$69,337
657	8,948	$47,184
658	6,766	$38,188
659	4,018	$61,879
660	8,479	$42,858

MS-DRG	Number of Cases	Threshold
661	3,839	$35,203
662	784	$53,885
663	2,021	$35,573
664	3,239	$30,070
665	566	$54,989
666	2,163	$37,454
667	2,567	$21,615
668	3,046	$50,857
669	14,589	$33,947
670	8,666	$21,738
671	794	$34,958
672	623	$21,894
673	11,536	$52,527
674	9,435	$45,848
675	3,189	$37,262
682	97,779	$34,646
683	116,267	$26,797
684	26,439	$17,873
685	2,431	$23,004
686	1,125	$38,635
687	3,379	$28,822
688	696	$18,957
689	60,262	$29,883
690	211,669	$20,772
691	988	$39,844
692	374	$29,304
693	1,759	$33,992
694	17,619	$21,438
695	1,079	$29,342
696	10,126	$17,358
697	503	$20,989
698	23,155	$34,037
699	31,521	$26,277
700	8,022	$18,277
707	5,367	$43,530
708	16,736	$36,072
709	808	$38,810
710	1,468	$32,528
711	737	$38,903
712	419	$23,053
713	9,712	$30,909
714	22,381	$17,919

MS-DRG	Number of Cases	Threshold
715	505	$39,884
716	680	$32,540
717	730	$35,442
718	442	$22,068
722	471	$34,120
723	1,924	$27,787
724	270	$17,265
725	465	$30,880
726	3,874	$18,869
727	1,503	$31,710
728	6,041	$20,493
729	825	$25,903
730	270	$17,507
734	1,500	$49,487
735	1,131	$32,995
736	899	$83,400
737	3,234	$47,188
738	711	$34,014
739	893	$63,484
740	4,404	$39,292
741	5,326	$30,532
742	10,757	$35,840
743	27,508	$25,332
744	1,597	$35,184
745	1,245	$24,011
746	2,586	$34,114
747	7,182	$24,836
748	16,937	$25,356
749	1,039	$49,153
750	357	$25,812
754	1,013	$39,933
755	3,368	$28,953
756	428	$18,241
757	1,306	$36,002
758	2,201	$29,210
759	965	$20,006
760	2,233	$22,294
761	1,115	$15,121
765	3,379	$23,255
766	2,738	$15,815
767	158	$18,847
769	120	$36,097

MS-DRG	Number of Cases	Threshold
770	169	$19,277
774	1,649	$13,882
775	5,878	$10,102
776	590	$17,342
777	193	$22,330
778	443	$10,987
779	100	$13,618
780	41	$4,964
781	3,338	$15,998
782	183	$10,943
799	536	$93,658
800	683	$56,120
801	356	$39,493
802	925	$61,030
803	1,151	$41,927
804	749	$30,509
808	7,891	$42,091
809	14,192	$30,007
810	2,151	$25,037
811	28,551	$29,855
812	97,149	$21,229
813	11,326	$30,814
814	1,581	$35,709
815	3,746	$27,757
816	1,507	$19,866
820	1,253	$100,725
821	2,044	$50,392
822	1,717	$33,802
823	1,856	$83,150
824	3,096	$50,650
825	1,424	$33,826
826	595	$86,032
827	1,483	$47,738
828	695	$36,559
829	1,377	$51,734
830	378	$31,661
834	3,657	$70,088
835	3,007	$39,821
836	1,194	$26,540
837	1,263	$106,272
838	1,521	$53,857
839	1,277	$31,274

MS-DRG	Number of Cases	Threshold
840	7,480	$51,366
841	10,825	$36,282
842	3,610	$28,007
843	1,470	$38,732
844	2,937	$30,298
845	661	$22,819
846	2,604	$42,145
847	21,805	$29,250
848	1,097	$24,444
849	1,146	$32,369
853	38,565	$91,272
854	8,670	$55,722
855	336	$34,434
856	5,855	$76,412
857	9,736	$41,649
858	2,323	$32,601
862	9,415	$37,927
863	21,516	$24,874
864	18,011	$22,913
865	2,252	$32,413
866	7,371	$20,686
867	5,258	$44,090
868	2,839	$28,523
869	780	$18,866
870	24,860	$106,502
871	243,777	$39,851
872	109,504	$29,902
876	644	$47,279
880	7,998	$17,687
881	4,485	$13,773
882	1,777	$13,817
883	857	$21,001
884	17,804	$21,880
885	86,078	$17,440
886	516	$16,551
887	457	$20,944
894	4,334	$9,344
895	6,227	$18,729
896	6,841	$31,361
897	35,562	$15,859
901	908	$59,414
902	1,866	$36,298

MS-DRG	Number of Cases	Threshold
903	1,023	$27,605
904	1,875	$50,261
905	761	$30,007
906	707	$27,780
907	8,595	$64,245
908	8,972	$41,012
909	4,716	$30,957
913	869	$31,194
914	5,410	$19,231
915	1,403	$32,145
916	5,542	$12,731
917	18,890	$33,845
918	36,304	$17,045
919	10,656	$34,105
920	15,111	$25,896
921	7,216	$16,847
922	1,034	$31,694
923	3,162	$18,180
927	187	$189,898
928	944	$70,359
929	361	$39,859
933	137	$34,574
934	606	$27,093
935	2,090	$25,625
939	708	$53,797
940	1,607	$38,271
941	1,433	$31,284
945	5,862	$21,952
946	2,777	$19,453
947	12,110	$28,176
948	54,704	$18,655
949	619	$24,242
950	269	$12,506
951	979	$16,819
955	445	$101,857
956	4,439	$63,799
957	1,466	$115,563
958	1,242	$75,833
959	211	$51,094
963	1,795	$54,915
964	2,930	$36,033
965	918	$25,829
969	619	$87,601
970	101	$55,046
974	5,156	$46,685
975	4,444	$31,911
976	1,503	$24,729
977	3,507	$27,465
981	25,206	$87,362
982	19,424	$58,230
983	4,770	$41,100
984	505	$63,280
985	1,049	$46,036
986	435	$30,120
987	7,864	$61,346
988	10,822	$41,591
989	3,900	$29,376
999	16	$25,241

[1]Cases taken from the FY 2009 MedPAR file; MS-DRGs are from GROUPER Version 28.0.

TABLE 11.— MS-LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011 UNDER THE LTCH PPS

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
1	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	0	0.0000	0.0	0.0
2	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	0	0.0000	0.0	0.0
3	3	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	274	4.6614	66.1	55.1
4	4	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	1,536	2.9327	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

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
11	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	1	1.0928	29.1	24.3
12	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	0	0.8691	23.3	19.4
13	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	0	0.4984	18.1	15.1
14	14	ALLOGENEIC BONE MARROW TRANSPLANT	0	0.5518	19.4	16.2
15	15	AUTOLOGOUS BONE MARROW TRANSPLANT	0	0.5518	19.4	16.2
20	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	1	1.6523	36.5	30.4
21	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	0	0.6024	22.1	18.4
22	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	0	0.4984	18.1	15.1
23	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	0	1.0928	29.1	24.3
24	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	0	0.4984	18.1	15.1
25	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	2	1.0928	29.1	24.3
26	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	1	0.4984	18.1	15.1
27	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	0	0.4984	18.1	15.1
28	28	SPINAL PROCEDURES W MCC	11	1.0928	29.1	24.3
29	28	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	16	0.8659	24.5	20.4
30	28	SPINAL PROCEDURES W/O CC/MCC	0	0.8659	24.5	20.4
31	31	VENTRICULAR SHUNT PROCEDURES W MCC	1	1.0928	29.1	24.3
32	31	VENTRICULAR SHUNT PROCEDURES W CC	0	1.0928	29.1	24.3
33	31	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
34	34	CAROTID ARTERY STENT PROCEDURE W MCC	0	1.6523	36.5	30.4
35	34	CAROTID ARTERY STENT PROCEDURE W CC	0	1.6523	36.5	30.4
36	34	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	0	1.6523	36.5	30.4
37	37	EXTRACRANIAL PROCEDURES W MCC*	13	1.6523	36.5	30.4
38	37	EXTRACRANIAL PROCEDURES W CC	4	1.6523	36.5	30.4
39	37	EXTRACRANIAL PROCEDURES W/O CC/MCC	0	1.6523	36.5	30.4
40	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	118	1.2780	34.4	28.7
41	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	82	0.8894	29.0	24.2
42	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	3	0.4984	18.1	15.1
52	52	SPINAL DISORDERS & INJURIES W CC/MCC	65	1.1250	41.6	34.7
53	52	SPINAL DISORDERS & INJURIES W/O CC/MCC*	6	1.1250	41.6	34.7
54	54	NERVOUS SYSTEM NEOPLASMS W MCC	33	0.7917	26.4	22.0
55	54	NERVOUS SYSTEM NEOPLASMS W/O MCC	35	0.5822	19.2	16.0
56	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1,121	0.8073	25.7	21.4
57	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1,140	0.5719	23.7	19.8
58	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	11	1.6523	36.5	30.4
59	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	14	0.6257	21.2	17.7
60	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	4	0.4984	18.1	15.1
61	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	0	0.9165	23.3	19.4
62	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	0	0.6128	22.1	18.4
63	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	0	0.6128	22.1	18.4
64	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	144	0.8345	24.0	20.0
65	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	52	0.6024	22.1	18.4
66	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	9	0.4984	18.1	15.1
67	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	0	0.4984	18.1	15.1
68	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	3	0.4984	18.1	15.1
69	69	TRANSIENT ISCHEMIA	2	1.0928	29.1	24.3
70	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	182	0.9165	23.3	19.4
71	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	92	0.6128	22.1	18.4
72	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC*	9	0.6128	22.1	18.4
73	73	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	112	0.8656	24.9	20.8
74	73	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	111	0.6356	21.9	18.3
75	75	VIRAL MENINGITIS W CC/MCC	9	0.8659	24.5	20.4
76	75	VIRAL MENINGITIS W/O CC/MCC	0	0.8659	24.5	20.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
77	77	HYPERTENSIVE ENCEPHALOPATHY W MCC	2	0.8659	24.5	20.4
78	77	HYPERTENSIVE ENCEPHALOPATHY W CC	2	0.8659	24.5	20.4
79	77	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0	0.6257	21.2	17.7
80	80	NONTRAUMATIC STUPOR & COMA W MCC	8	1.0928	29.1	24.3
81	80	NONTRAUMATIC STUPOR & COMA W/O MCC	6	0.4984	18.1	15.1
82	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	15	0.8659	24.5	20.4
83	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	9	0.6257	21.2	17.7
84	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	1	0.4984	18.1	15.1
85	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	93	0.9264	24.9	20.8
86	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	56	0.6841	23.9	19.9
87	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	8	0.4984	18.1	15.1
88	88	CONCUSSION W MCC	0	1.0928	29.1	24.3
89	88	CONCUSSION W CC	1	1.0928	29.1	24.3
90	88	CONCUSSION W/O CC/MCC	1	0.8659	24.5	20.4
91	91	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	268	0.8778	24.3	20.3
92	91	OTHER DISORDERS OF NERVOUS SYSTEM W CC	98	0.7453	24.2	20.2
93	91	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	7	0.4984	18.1	15.1
94	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	247	1.1095	29.4	24.5
95	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	100	0.8174	25.3	21.1
96	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC*	22	0.8174	25.3	21.1
97	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	70	0.9173	24.6	20.5
98	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	23	0.6257	21.2	17.7
99	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	4	0.4984	18.1	15.1
100	100	SEIZURES W MCC	32	0.7231	21.5	17.9
101	100	SEIZURES W/O MCC	36	0.6145	21.8	18.2
102	102	HEADACHES W MCC	2	0.8659	24.5	20.4
103	102	HEADACHES W/O MCC	0	0.4984	18.1	15.1
113	113	ORBITAL PROCEDURES W CC/MCC	1	1.0928	29.1	24.3
114	113	ORBITAL PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
115	115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	0	1.0928	29.1	24.3
116	116	INTRAOCULAR PROCEDURES W CC/MCC	0	1.0928	29.1	24.3
117	116	INTRAOCULAR PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
121	121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	9	0.6257	21.2	17.7
122	121	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	3	0.4984	18.1	15.1
123	123	NEUROLOGICAL EYE DISORDERS	0	1.0928	29.1	24.3
124	124	OTHER DISORDERS OF THE EYE W MCC*	6	1.0928	29.1	24.3
125	124	OTHER DISORDERS OF THE EYE W/O MCC	3	1.0928	29.1	24.3
129	129	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	0	1.2604	27.1	22.6
130	129	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	0	0.4984	18.1	15.1
131	131	CRANIAL/FACIAL PROCEDURES W CC/MCC	1	1.6523	36.5	30.4
132	131	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	0	0.6014	19.6	16.3
133	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	9	1.6523	36.5	30.4
134	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0	0.4984	18.1	15.1
135	135	SINUS & MASTOID PROCEDURES W CC/MCC	0	1.6523	36.5	30.4
136	135	SINUS & MASTOID PROCEDURES W/O CC/MCC	0	0.4984	18.1	15.1
137	137	MOUTH PROCEDURES W CC/MCC	0	0.6257	21.2	17.7
138	137	MOUTH PROCEDURES W/O CC/MCC	0	0.6257	21.2	17.7
139	139	SALIVARY GLAND PROCEDURES	0	0.6257	21.2	17.7
146	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	39	1.2604	27.1	22.6
147	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	31	0.8691	23.3	19.4
148	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	3	0.4984	18.1	15.1
149	149	DYSEQUILIBRIUM	2	0.4984	18.1	15.1
150	150	EPISTAXIS W MCC	0	0.8541	25.4	21.2
151	150	EPISTAXIS W/O MCC	1	0.4984	18.1	15.1
152	152	OTITIS MEDIA & URI W MCC	31	0.8541	25.4	21.2
153	152	OTITIS MEDIA & URI W/O MCC	28	0.5959	19.9	16.6
154	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	50	1.0563	26.2	21.8
155	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	42	0.6014	19.6	16.3
156	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC*	8	0.6014	19.6	16.3
157	157	DENTAL & ORAL DISEASES W MCC	9	1.0928	29.1	24.3
158	157	DENTAL & ORAL DISEASES W CC	24	0.6257	21.2	17.7

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
159	157	DENTAL & ORAL DISEASES W/O CC/MCC	4	0.6257	21.2	17.7
163	163	MAJOR CHEST PROCEDURES W MCC	28	2.4258	42.0	35.0
164	163	MAJOR CHEST PROCEDURES W CC	5	1.6523	36.5	30.4
165	163	MAJOR CHEST PROCEDURES W/O CC/MCC	0	1.5261	31.3	26.1
166	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	1,755	2.6005	42.2	35.2
167	166	OTHER RESP SYSTEM O.R. PROCEDURES W CC	175	1.5261	31.3	26.1
168	166	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC*	8	1.5261	31.3	26.1
175	175	PULMONARY EMBOLISM W MCC	105	0.7484	22.7	18.9
176	175	PULMONARY EMBOLISM W/O MCC	72	0.5472	18.8	15.7
177	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	4,080	0.8886	22.9	19.1
178	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1,915	0.7176	20.8	17.3
179	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	143	0.5980	17.1	14.3
180	180	RESPIRATORY NEOPLASMS W MCC	116	0.7504	19.9	16.6
181	180	RESPIRATORY NEOPLASMS W CC	64	0.6594	19.9	16.6
182	180	RESPIRATORY NEOPLASMS W/O CC/MCC	2	0.6257	21.2	17.7
183	183	MAJOR CHEST TRAUMA W MCC	0	2.4258	42.0	35.0
184	183	MAJOR CHEST TRAUMA W CC	0	1.6523	36.5	30.4
185	183	MAJOR CHEST TRAUMA W/O CC/MCC	0	1.5261	31.3	26.1
186	186	PLEURAL EFFUSION W MCC	149	0.7400	20.8	17.3
187	186	PLEURAL EFFUSION W CC	41	0.5680	18.8	15.7
188	186	PLEURAL EFFUSION W/O CC/MCC	3	0.4984	18.1	15.1
189	189	PULMONARY EDEMA & RESPIRATORY FAILURE	8,413	0.9736	23.6	19.7
190	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	2,362	0.7398	20.2	16.8
191	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	1,129	0.6312	18.5	15.4
192	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	287	0.5082	16.5	13.8
193	193	SIMPLE PNEUMONIA & PLEURISY W MCC	2,122	0.7620	20.9	17.4
194	193	SIMPLE PNEUMONIA & PLEURISY W CC	1,558	0.6138	18.9	15.8
195	193	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	162	0.4864	16.7	13.9
196	196	INTERSTITIAL LUNG DISEASE W MCC	96	0.7018	20.4	17.0
197	196	INTERSTITIAL LUNG DISEASE W CC	71	0.6031	18.6	15.5
198	196	INTERSTITIAL LUNG DISEASE W/O CC/MCC	20	0.4984	18.1	15.1
199	199	PNEUMOTHORAX W MCC	81	0.7732	21.5	17.9
200	199	PNEUMOTHORAX W CC	15	0.6257	21.2	17.7
201	199	PNEUMOTHORAX W/O CC/MCC	4	0.4984	18.1	15.1
202	202	BRONCHITIS & ASTHMA W CC/MCC	114	0.7195	20.9	17.4
203	202	BRONCHITIS & ASTHMA W/O CC/MCC	10	0.6257	21.2	17.7
204	204	RESPIRATORY SIGNS & SYMPTOMS	145	0.7747	21.1	17.6
205	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	380	0.8269	22.1	18.4
206	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	145	0.7006	20.7	17.3
207	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	14,832	2.0259	33.4	27.8
208	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	1,839	1.0942	22.3	18.6
215	215	OTHER HEART ASSIST SYSTEM IMPLANT	0	0.6257	21.2	17.7
216	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	0	1.6523	36.5	30.4
217	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	0	1.2453	30.4	25.3
218	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	0	0.6257	21.2	17.7
219	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	0	1.6523	36.5	30.4
220	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	1	1.6523	36.5	30.4
221	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	0	0.6257	21.2	17.7
222	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	0	1.6523	36.5	30.4
223	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	0	0.8659	24.5	20.4
224	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	0	1.6523	36.5	30.4
225	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	1	0.6257	21.2	17.7
226	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6	1.6523	36.5	30.4
227	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	2	1.6523	36.5	30.4
228	228	OTHER CARDIOTHORACIC PROCEDURES W MCC	0	1.3768	30.1	25.1
229	228	OTHER CARDIOTHORACIC PROCEDURES W CC	0	1.2453	30.4	25.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
230	228	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	0	0.6257	21.2	17.7
231	231	CORONARY BYPASS W PTCA W MCC	0	1.6523	36.5	30.4
232	231	CORONARY BYPASS W PTCA W/O MCC	0	0.6257	21.2	17.7
233	233	CORONARY BYPASS W CARDIAC CATH W MCC	0	1.6523	36.5	30.4
234	233	CORONARY BYPASS W CARDIAC CATH W/O MCC	0	0.6257	21.2	17.7
235	235	CORONARY BYPASS W/O CARDIAC CATH W MCC	0	1.6523	36.5	30.4
236	235	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	1	0.6257	21.2	17.7
237	237	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	6	1.6523	36.5	30.4
238	237	MAJOR CARDIOVASC PROCEDURES W/O MCC	0	0.6257	21.2	17.7
239	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	143	1.5473	37.0	30.8
240	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	55	1.3389	35.0	29.2
241	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	0	0.6257	21.2	17.7
242	242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3	1.6523	36.5	30.4
243	242	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	6	0.8659	24.5	20.4
244	242	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	1	0.4984	18.1	15.1
245	245	AICD GENERATOR PROCEDURES	0	0.4984	18.1	15.1
246	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	0	1.3768	30.1	25.1
247	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2	0.8659	24.5	20.4
248	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	1	1.6523	36.5	30.4
249	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1	0.6257	21.2	17.7
250	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	3	1.0928	29.1	24.3
251	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	0	1.0928	29.1	24.3
252	252	OTHER VASCULAR PROCEDURES W MCC	111	1.3768	30.1	25.1
253	252	OTHER VASCULAR PROCEDURES W CC	46	1.2453	30.4	25.3
254	252	OTHER VASCULAR PROCEDURES W/O CC/MCC	2	0.6257	21.2	17.7
255	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	37	1.2172	33.9	28.3
256	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	22	1.0928	29.1	24.3
257	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0	0.6257	21.2	17.7
258	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	1	0.8659	24.5	20.4
259	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	0	0.6257	21.2	17.7
260	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3	1.6523	36.5	30.4
261	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	3	1.0928	29.1	24.3
262	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1	0.6257	21.2	17.7
263	263	VEIN LIGATION & STRIPPING	2	1.6523	36.5	30.4
264	264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	594	1.0425	30.6	25.5
265	265	AICD LEAD PROCEDURES	0	1.0425	30.6	25.5
280	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	273	0.7702	22.3	18.6
281	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	105	0.6645	20.9	17.4
282	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	12	0.4984	18.1	15.1
283	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	46	0.9061	17.2	14.3
284	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	6	0.6257	21.2	17.7
285	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0	0.6257	21.2	17.7
286	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	11	1.6523	36.5	30.4
287	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	5	0.8659	24.5	20.4
288	288	ACUTE & SUBACUTE ENDOCARDITIS W MCC	647	1.0246	26.3	21.9
289	288	ACUTE & SUBACUTE ENDOCARDITIS W CC	241	0.8422	26.2	21.8
290	288	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	25	0.7590	27.8	23.2
291	291	HEART FAILURE & SHOCK W MCC	1,435	0.7751	21.4	17.8
292	291	HEART FAILURE & SHOCK W CC	874	0.6119	19.6	16.3
293	291	HEART FAILURE & SHOCK W/O CC/MCC	82	0.4369	16.8	14.0
294	294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	8	1.6523	36.5	30.4
295	294	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0	0.5138	20.0	16.7
296	296	CARDIAC ARREST, UNEXPLAINED W MCC	0	0.7751	21.4	17.8
297	296	CARDIAC ARREST, UNEXPLAINED W CC	0	0.6119	19.6	16.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
298	296	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0	0.4369	16.8	14.0
299	299	PERIPHERAL VASCULAR DISORDERS W MCC	735	0.7957	23.7	19.8
300	299	PERIPHERAL VASCULAR DISORDERS W CC	697	0.5828	21.6	18.0
301	299	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	39	0.5138	20.0	16.7
302	302	ATHEROSCLEROSIS W MCC	49	0.8777	22.6	18.8
303	302	ATHEROSCLEROSIS W/O MCC	38	0.5638	21.5	17.9
304	304	HYPERTENSION W MCC	3	1.6523	36.5	30.4
305	304	HYPERTENSION W/O MCC	14	0.6257	21.2	17.7
306	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	58	0.8585	24.3	20.3
307	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	37	0.8106	24.4	20.3
308	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	130	0.7110	20.7	17.3
309	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	55	0.5285	19.3	16.1
310	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	11	0.4984	18.1	15.1
311	311	ANGINA PECTORIS	1	0.8659	24.5	20.4
312	312	SYNCOPE & COLLAPSE	29	0.4979	17.3	14.4
313	313	CHEST PAIN	3	0.8659	24.5	20.4
314	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1,569	0.9040	23.1	19.3
315	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	317	0.6805	21.5	17.9
316	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	26	0.5373	19.2	16.0
326	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	24	1.6523	36.5	30.4
327	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	3	0.8659	24.5	20.4
328	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1	0.8659	24.5	20.4
329	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	28	1.7735	41.2	34.3
330	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	8	1.6523	36.5	30.4
331	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
332	332	RECTAL RESECTION W MCC	0	1.0928	29.1	24.3
333	332	RECTAL RESECTION W CC	0	0.8659	24.5	20.4
334	332	RECTAL RESECTION W/O CC/MCC	0	0.8659	24.5	20.4
335	335	PERITONEAL ADHESIOLYSIS W MCC	10	1.6523	36.5	30.4
336	335	PERITONEAL ADHESIOLYSIS W CC	1	1.0928	29.1	24.3
337	335	PERITONEAL ADHESIOLYSIS W/O CC/MCC	0	1.0928	29.1	24.3
338	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	0	0.7232	22.0	18.3
339	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	0	0.7232	22.0	18.3
340	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5057	17.1	14.3
341	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	0	0.9532	24.3	20.3
342	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	0	0.7232	22.0	18.3
343	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5057	17.1	14.3
344	344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC*	1	1.0928	29.1	24.3
345	344	MINOR SMALL & LARGE BOWEL PROCEDURES W CC*	1	1.0928	29.1	24.3
346	344	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
347	347	ANAL & STOMAL PROCEDURES W MCC	3	1.0928	29.1	24.3
348	347	ANAL & STOMAL PROCEDURES W CC	2	0.8659	24.5	20.4
349	347	ANAL & STOMAL PROCEDURES W/O CC/MCC	0	0.8659	24.5	20.4
350	350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	1	1.6523	36.5	30.4
351	350	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	0	0.4984	18.1	15.1
352	350	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0	0.4984	18.1	15.1
353	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	3	1.0928	29.1	24.3
354	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1	0.4984	18.1	15.1
355	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	0	0.4984	18.1	15.1
356	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	141	1.7067	35.6	29.7
357	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	26	1.1269	29.0	24.2
358	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	3	1.0928	29.1	24.3
368	368	MAJOR ESOPHAGEAL DISORDERS W MCC	34	1.0396	22.4	18.7
369	368	MAJOR ESOPHAGEAL DISORDERS W CC	12	0.6257	21.2	17.7
370	368	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC*	1	0.6257	21.2	17.7
371	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	949	0.9532	24.3	20.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
372	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	342	0.7232	22.0	18.3
373	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	31	0.5057	17.1	14.3
374	374	DIGESTIVE MALIGNANCY W MCC	102	0.8196	20.9	17.4
375	374	DIGESTIVE MALIGNANCY W CC	56	0.6753	21.3	17.8
376	374	DIGESTIVE MALIGNANCY W/O CC/MCC	3	0.4984	18.1	15.1
377	377	G.I. HEMORRHAGE W MCC	88	0.7954	22.5	18.8
378	377	G.I. HEMORRHAGE W CC	43	0.6146	21.3	17.8
379	377	G.I. HEMORRHAGE W/O CC/MCC	7	0.4984	18.1	15.1
380	380	COMPLICATED PEPTIC ULCER W MCC	22	1.0928	29.1	24.3
381	380	COMPLICATED PEPTIC ULCER W CC	17	0.8659	24.5	20.4
382	380	COMPLICATED PEPTIC ULCER W/O CC/MCC	1	0.8659	24.5	20.4
383	383	UNCOMPLICATED PEPTIC ULCER W MCC	9	0.4984	18.1	15.1
384	383	UNCOMPLICATED PEPTIC ULCER W/O MCC*	5	0.4984	18.1	15.1
385	385	INFLAMMATORY BOWEL DISEASE W MCC	32	0.9116	23.3	19.4
386	385	INFLAMMATORY BOWEL DISEASE W CC	25	0.7326	25.4	21.2
387	385	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	2	0.4984	18.1	15.1
388	388	G.I. OBSTRUCTION W MCC	218	0.9421	23.4	19.5
389	388	G.I. OBSTRUCTION W CC	83	0.6300	19.8	16.5
390	388	G.I. OBSTRUCTION W/O CC/MCC	10	0.4984	18.1	15.1
391	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	342	0.9344	23.3	19.4
392	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	195	0.6339	20.0	16.7
393	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	975	1.0713	25.8	21.5
394	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	388	0.7529	21.8	18.2
395	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	17	0.6257	21.2	17.7
405	405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	17	1.6523	36.5	30.4
406	405	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2	1.0928	29.1	24.3
407	405	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	0	0.6257	21.2	17.7
408	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	1	1.6523	36.5	30.4
409	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	1	0.8659	24.5	20.4
410	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	0	0.6257	21.2	17.7
411	411	CHOLECYSTECTOMY W C.D.E. W MCC	1	1.6523	36.5	30.4
412	411	CHOLECYSTECTOMY W C.D.E. W CC	0	1.6523	36.5	30.4
413	411	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	0	0.6257	21.2	17.7
414	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	0	1.6523	36.5	30.4
415	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0	1.6523	36.5	30.4
416	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1	1.6523	36.5	30.4
417	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	10	1.6523	36.5	30.4
418	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	2	1.6523	36.5	30.4
419	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1	0.6257	21.2	17.7
420	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	0	1.6523	36.5	30.4
421	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	0	1.6523	36.5	30.4
422	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	0	1.6523	36.5	30.4
423	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	17	1.6523	36.5	30.4
424	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	3	1.6523	36.5	30.4
425	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	0	1.6523	36.5	30.4
432	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	80	0.6649	20.3	16.9
433	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	11	0.6257	21.2	17.7
434	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0	0.6257	21.2	17.7
435	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	41	0.8824	20.1	16.8
436	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	11	0.4984	18.1	15.1
437	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	1	0.4984	18.1	15.1
438	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	311	1.0472	23.7	19.8
439	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	122	0.7526	21.1	17.6
440	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	13	0.4984	18.1	15.1
441	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	230	0.8014	22.2	18.5
442	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	73	0.7063	23.0	19.2

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
443	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC*	8	0.7063	23.0	19.2
444	444	DISORDERS OF THE BILIARY TRACT W MCC	128	0.7774	21.8	18.2
445	444	DISORDERS OF THE BILIARY TRACT W CC	48	0.5869	20.6	17.2
446	444	DISORDERS OF THE BILIARY TRACT W/O CC/MCC*	12	0.5869	20.6	17.2
453	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	0	1.6523	36.5	30.4
454	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	0	1.6523	36.5	30.4
455	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	0	1.0928	29.1	24.3
456	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	2	1.6523	36.5	30.4
457	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	0	1.6523	36.5	30.4
458	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	0	1.0928	29.1	24.3
459	459	SPINAL FUSION EXCEPT CERVICAL W MCC	2	1.6523	36.5	30.4
460	459	SPINAL FUSION EXCEPT CERVICAL W/O MCC	1	1.0928	29.1	24.3
461	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	0	1.6523	36.5	30.4
462	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	0	1.6523	36.5	30.4
463	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	845	1.4169	39.1	32.6
464	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	307	1.0921	34.3	28.6
465	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	23	0.8659	24.5	20.4
466	466	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4	1.6523	36.5	30.4
467	466	REVISION OF HIP OR KNEE REPLACEMENT W CC	1	0.8659	24.5	20.4
468	466	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	0	0.8659	24.5	20.4
469	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	2	1.6523	36.5	30.4
470	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2	1.6523	36.5	30.4
471	471	CERVICAL SPINAL FUSION W MCC	0	1.0928	29.1	24.3
472	471	CERVICAL SPINAL FUSION W CC	1	1.0928	29.1	24.3
473	471	CERVICAL SPINAL FUSION W/O CC/MCC	0	1.0928	29.1	24.3
474	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	140	1.3818	36.9	30.8
475	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	51	1.0985	34.1	28.4
476	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	4	0.6257	21.2	17.7
477	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	32	1.3895	38.2	31.8
478	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	13	1.0928	29.1	24.3
479	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC*	1	1.0928	29.1	24.3
480	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC*	13	1.6523	36.5	30.4
481	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	6	1.6523	36.5	30.4
482	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1	1.6523	36.5	30.4
483	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	0	1.6523	36.5	30.4
484	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	0	1.6523	36.5	30.4
485	485	KNEE PROCEDURES W PDX OF INFECTION W MCC	11	1.0928	29.1	24.3
486	485	KNEE PROCEDURES W PDX OF INFECTION W CC	9	1.0928	29.1	24.3
487	485	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	2	0.6257	21.2	17.7
488	488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	0	1.0928	29.1	24.3
489	488	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	0	0.6257	21.2	17.7
490	490	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	9	1.0928	29.1	24.3
491	490	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	2	0.4984	18.1	15.1
492	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC*	11	1.6523	36.5	30.4
493	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	17	1.6523	36.5	30.4
494	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1	0.8659	24.5	20.4
495	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	81	1.4575	37.6	31.3
496	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	22	1.0928	29.1	24.3
497	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1	1.0928	29.1	24.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
498	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	18	1.6523	36.5	30.4
499	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1	0.8659	24.5	20.4
500	500	SOFT TISSUE PROCEDURES W MCC	131	1.3739	36.8	30.7
501	500	SOFT TISSUE PROCEDURES W CC	38	0.9640	30.7	25.6
502	500	SOFT TISSUE PROCEDURES W/O CC/MCC	5	0.6257	21.2	17.7
503	503	FOOT PROCEDURES W MCC	33	1.0057	31.5	26.3
504	503	FOOT PROCEDURES W CC*	22	1.0057	31.5	26.3
505	503	FOOT PROCEDURES W/O CC/MCC*	2	1.0057	31.5	26.3
506	506	MAJOR THUMB OR JOINT PROCEDURES	1	0.8659	24.5	20.4
507	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	2	1.6523	36.5	30.4
508	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	0	0.8659	24.5	20.4
509	509	ARTHROSCOPY	2	1.6523	36.5	30.4
510	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	0	1.3877	32.0	26.7
511	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	0	0.8659	24.5	20.4
512	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	0	0.8659	24.5	20.4
513	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	8	1.0928	29.1	24.3
514	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0	0.8659	24.5	20.4
515	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	84	1.3877	32.0	26.7
516	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	23	0.8659	24.5	20.4
517	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC*	5	0.8659	24.5	20.4
533	533	FRACTURES OF FEMUR W MCC	3	1.0928	29.1	24.3
534	533	FRACTURES OF FEMUR W/O MCC	1	1.0928	29.1	24.3
535	535	FRACTURES OF HIP & PELVIS W MCC	26	0.7405	25.4	21.2
536	535	FRACTURES OF HIP & PELVIS W/O MCC	13	0.6257	21.2	17.7
537	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	1	0.4984	18.1	15.1
538	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0	0.4984	18.1	15.1
539	539	OSTEOMYELITIS W MCC	1,935	1.0119	30.8	25.7
540	539	OSTEOMYELITIS W CC	964	0.7934	27.5	22.9
541	539	OSTEOMYELITIS W/O CC/MCC	149	0.6794	24.4	20.3
542	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	37	0.9220	21.9	18.3
543	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	25	0.6916	22.1	18.4
544	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	4	0.6257	21.2	17.7
545	545	CONNECTIVE TISSUE DISORDERS W MCC	61	0.8780	21.8	18.2
546	545	CONNECTIVE TISSUE DISORDERS W CC	47	0.7139	24.1	20.1
547	545	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	2	0.4984	18.1	15.1
548	548	SEPTIC ARTHRITIS W MCC	260	0.9174	27.2	22.7
549	548	SEPTIC ARTHRITIS W CC	215	0.7449	26.6	22.2
550	548	SEPTIC ARTHRITIS W/O CC/MCC	39	0.5723	25.1	20.9
551	551	MEDICAL BACK PROBLEMS W MCC	130	0.9045	26.3	21.9
552	551	MEDICAL BACK PROBLEMS W/O MCC	116	0.5917	21.7	18.1
553	553	BONE DISEASES & ARTHROPATHIES W MCC	6	0.4984	18.1	15.1
554	553	BONE DISEASES & ARTHROPATHIES W/O MCC*	17	0.4984	18.1	15.1
555	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC*	15	0.6257	21.2	17.7
556	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	12	0.6257	21.2	17.7
557	557	TENDONITIS, MYOSITIS & BURSITIS W MCC	115	0.8843	26.2	21.8
558	557	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	110	0.6310	21.9	18.3
559	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1,723	0.8457	25.6	21.3
560	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1,416	0.6951	25.0	20.8
561	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	245	0.5767	22.9	19.1
562	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	13	0.8659	24.5	20.4
563	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	14	0.8659	24.5	20.4
564	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	387	0.8685	23.6	19.7
565	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	206	0.6709	22.7	18.9
566	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	26	0.5443	19.2	16.0
573	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	1,868	1.3682	38.3	31.9
574	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1,166	1.0282	34.5	28.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
575	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	78	0.7597	28.0	23.3
576	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	45	1.4427	38.4	32.0
577	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	25	0.9741	30.9	25.8
578	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	3	0.4984	18.1	15.1
579	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	631	1.3110	35.4	29.5
580	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	316	0.9362	31.7	26.4
581	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	13	0.8659	24.5	20.4
582	582	MASTECTOMY FOR MALIGNANCY W CC/MCC	0	1.6523	36.5	30.4
583	582	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0	0.5982	20.1	16.8
584	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	4	0.6257	21.2	17.7
585	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	0	0.6013	22.4	18.7
592	592	SKIN ULCERS W MCC	3,461	0.9179	26.5	22.1
593	592	SKIN ULCERS W CC	2,185	0.6848	25.1	20.9
594	592	SKIN ULCERS W/O CC/MCC	150	0.5626	23.1	19.3
595	595	MAJOR SKIN DISORDERS W MCC	48	0.9065	24.7	20.6
596	595	MAJOR SKIN DISORDERS W/O MCC	33	0.5982	20.1	16.8
597	597	MALIGNANT BREAST DISORDERS W MCC	15	1.6523	36.5	30.4
598	597	MALIGNANT BREAST DISORDERS W CC	11	0.4984	18.1	15.1
599	597	MALIGNANT BREAST DISORDERS W/O CC/MCC	0	0.4984	18.1	15.1
600	600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	29	0.6616	24.0	20.0
601	600	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	5	0.4984	18.1	15.1
602	602	CELLULITIS W MCC	1,132	0.7278	22.1	18.4
603	602	CELLULITIS W/O MCC	1,521	0.5274	19.1	15.9
604	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	37	0.6464	23.4	19.5
605	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	51	0.6013	22.4	18.7
606	606	MINOR SKIN DISORDERS W MCC	95	0.8336	22.8	19.0
607	606	MINOR SKIN DISORDERS W/O MCC	96	0.5726	20.3	16.9
614	614	ADRENAL & PITUITARY PROCEDURES W CC/MCC	0	0.9768	28.8	24.0
615	614	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	0	0.8659	24.5	20.4
616	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	104	1.5743	39.7	33.1
617	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	115	1.0130	31.1	25.9
618	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	0	1.0130	31.1	25.9
619	619	O.R. PROCEDURES FOR OBESITY W MCC	3	1.0928	29.1	24.3
620	619	O.R. PROCEDURES FOR OBESITY W CC	0	1.0928	29.1	24.3
621	619	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	0	1.0928	29.1	24.3
622	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	263	1.2498	35.9	29.9
623	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	352	0.9964	30.8	25.7
624	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	9	0.6257	21.2	17.7
625	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	1	0.6257	21.2	17.7
626	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	0	0.6257	21.2	17.7
627	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0	0.6257	21.2	17.7
628	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	69	1.2290	32.9	27.4
629	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	109	0.9768	28.8	24.0
630	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	3	0.8659	24.5	20.4
637	637	DIABETES W MCC	686	0.8950	26.2	21.8
638	637	DIABETES W CC	1,044	0.7068	23.4	19.5
639	637	DIABETES W/O CC/MCC	33	0.4718	20.1	16.8
640	640	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	679	0.8730	23.1	19.3
641	640	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	467	0.6214	20.6	17.2
642	642	INBORN ERRORS OF METABOLISM	5	1.0928	29.1	24.3
643	643	ENDOCRINE DISORDERS W MCC	18	0.6257	21.2	17.7
644	643	ENDOCRINE DISORDERS W CC	18	0.6257	21.2	17.7
645	643	ENDOCRINE DISORDERS W/O CC/MCC	4	0.4984	18.1	15.1
652	652	KIDNEY TRANSPLANT	0	0.0000	0.0	0.0
653	653	MAJOR BLADDER PROCEDURES W MCC	1	1.6523	36.5	30.4
654	653	MAJOR BLADDER PROCEDURES W CC	0	1.0928	29.1	24.3
655	653	MAJOR BLADDER PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
656	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	1	0.4984	18.1	15.1
657	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	0	0.4984	18.1	15.1
658	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	0	0.4984	18.1	15.1
659	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC*	4	1.0928	29.1	24.3
660	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	4	1.0928	29.1	24.3
661	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	0	1.0928	29.1	24.3
662	662	MINOR BLADDER PROCEDURES W MCC	0	1.0928	29.1	24.3
663	662	MINOR BLADDER PROCEDURES W CC	1	1.0928	29.1	24.3
664	662	MINOR BLADDER PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
665	665	PROSTATECTOMY W MCC	2	1.0928	29.1	24.3
666	665	PROSTATECTOMY W CC	0	1.0928	29.1	24.3
667	665	PROSTATECTOMY W/O CC/MCC	0	1.0928	29.1	24.3
668	668	TRANSURETHRAL PROCEDURES W MCC	9	1.0928	29.1	24.3
669	668	TRANSURETHRAL PROCEDURES W CC	1	0.6257	21.2	17.7
670	668	TRANSURETHRAL PROCEDURES W/O CC/MCC	0	0.6257	21.2	17.7
671	671	URETHRAL PROCEDURES W CC/MCC	3	0.8659	24.5	20.4
672	671	URETHRAL PROCEDURES W/O CC/MCC	0	0.8659	24.5	20.4
673	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	213	1.3761	32.8	27.3
674	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	44	0.9744	27.9	23.3
675	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	3	0.8659	24.5	20.4
682	682	RENAL FAILURE W MCC	1,587	0.9092	23.1	19.3
683	682	RENAL FAILURE W CC	539	0.6866	21.0	17.5
684	682	RENAL FAILURE W/O CC/MCC	28	0.6184	17.1	14.3
685	685	ADMIT FOR RENAL DIALYSIS	1	1.0928	29.1	24.3
686	686	KIDNEY & URINARY TRACT NEOPLASMS W MCC	16	0.8659	24.5	20.4
687	686	KIDNEY & URINARY TRACT NEOPLASMS W CC	14	0.6257	21.2	17.7
688	686	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0	0.6257	21.2	17.7
689	689	KIDNEY & URINARY TRACT INFECTIONS W MCC	941	0.6702	21.7	18.1
690	689	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	681	0.5183	19.3	16.1
691	691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	0	0.8659	24.5	20.4
692	691	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	0	0.4984	18.1	15.1
693	693	URINARY STONES W/O ESW LITHOTRIPSY W MCC	11	0.8659	24.5	20.4
694	693	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	1	0.4984	18.1	15.1
695	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	5	0.8659	24.5	20.4
696	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	4	0.4984	18.1	15.1
697	697	URETHRAL STRICTURE	1	0.8659	24.5	20.4
698	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	345	0.8848	23.0	19.2
699	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	134	0.6293	20.2	16.8
700	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	11	0.6257	21.2	17.7
707	707	MAJOR MALE PELVIC PROCEDURES W CC/MCC	0	1.0928	29.1	24.3
708	707	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
709	709	PENIS PROCEDURES W CC/MCC	5	1.0928	29.1	24.3
710	709	PENIS PROCEDURES W/O CC/MCC	1	0.6257	21.2	17.7
711	711	TESTES PROCEDURES W CC/MCC	5	1.0928	29.1	24.3
712	711	TESTES PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
713	713	TRANSURETHRAL PROSTATECTOMY W CC/MCC	4	0.8659	24.5	20.4
714	713	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0	0.6257	21.2	17.7
715	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	0	1.6523	36.5	30.4
716	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0	1.0928	29.1	24.3
717	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	11	1.6523	36.5	30.4
718	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1	1.0928	29.1	24.3
722	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	8	1.0928	29.1	24.3
723	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	9	0.6257	21.2	17.7
724	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0	0.6257	21.2	17.7
725	725	BENIGN PROSTATIC HYPERTROPHY W MCC	2	1.6523	36.5	30.4
726	725	BENIGN PROSTATIC HYPERTROPHY W/O MCC	1	0.8659	24.5	20.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
727	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	74	0.8108	22.7	18.9
728	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	57	0.5010	17.3	14.4
729	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	69	0.8829	26.4	22.0
730	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	3	0.4984	18.1	15.1
734	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	0	1.0928	29.1	24.3
735	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	0	1.0928	29.1	24.3
736	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	0	1.0928	29.1	24.3
737	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	0	0.6257	21.2	17.7
738	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	0	0.6257	21.2	17.7
739	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	0	1.2290	32.9	27.4
740	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	0	0.9768	28.8	24.0
741	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	0	0.8659	24.5	20.4
742	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	0	0.9768	28.8	24.0
743	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0	0.8659	24.5	20.4
744	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	0	1.0928	29.1	24.3
745	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0	1.0928	29.1	24.3
746	746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	4	1.0928	29.1	24.3
747	746	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
748	748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0	1.0928	29.1	24.3
749	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	7	1.0928	29.1	24.3
750	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0	1.0928	29.1	24.3
754	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	17	1.0928	29.1	24.3
755	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	11	0.6257	21.2	17.7
756	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0	0.6257	21.2	17.7
757	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	72	0.7734	24.6	20.5
758	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	40	0.6833	23.9	19.9
759	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	7	0.4984	18.1	15.1
760	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC*	4	0.8659	24.5	20.4
761	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC*	2	0.8659	24.5	20.4
765	765	CESAREAN SECTION W CC/MCC	0	1.0928	29.1	24.3
766	765	CESAREAN SECTION W/O CC/MCC	0	1.0928	29.1	24.3
767	767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0	1.0928	29.1	24.3
768	768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0	1.0928	29.1	24.3
769	769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2	1.6523	36.5	30.4
770	770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0	1.0928	29.1	24.3
774	774	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0	1.0928	29.1	24.3
775	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0	1.0928	29.1	24.3
776	776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1	0.6257	21.2	17.7
777	777	ECTOPIC PREGNANCY	0	0.6257	21.2	17.7
778	778	THREATENED ABORTION	0	0.6257	21.2	17.7
779	779	ABORTION W/O D&C	0	0.6257	21.2	17.7
780	780	FALSE LABOR	0	0.6257	21.2	17.7
781	781	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	3	0.4984	18.1	15.1
782	782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0	0.4984	18.1	15.1
789	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0	0.4984	18.1	15.1
790	790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0	0.4984	18.1	15.1
791	791	PREMATURITY W MAJOR PROBLEMS	0	0.4984	18.1	15.1
792	792	PREMATURITY W/O MAJOR PROBLEMS	0	0.4984	18.1	15.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
793	793	FULL TERM NEONATE W MAJOR PROBLEMS	0	0.4984	18.1	15.1
794	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	0	0.4984	18.1	15.1
795	795	NORMAL NEWBORN	0	0.4984	18.1	15.1
799	799	SPLENECTOMY W MCC	0	1.0928	29.1	24.3
800	799	SPLENECTOMY W CC	0	1.0928	29.1	24.3
801	799	SPLENECTOMY W/O CC/MCC	0	1.0928	29.1	24.3
802	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	1	1.0928	29.1	24.3
803	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	0	1.0928	29.1	24.3
804	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	0	1.0928	29.1	24.3
808	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	12	0.8659	24.5	20.4
809	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	14	0.6257	21.2	17.7
810	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0	0.5518	19.4	16.2
811	811	RED BLOOD CELL DISORDERS W MCC	65	0.8420	21.1	17.6
812	811	RED BLOOD CELL DISORDERS W/O MCC	38	0.5518	19.4	16.2
813	813	COAGULATION DISORDERS	36	0.7371	21.2	17.7
814	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	30	0.8855	25.0	20.8
815	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	14	0.6257	21.2	17.7
816	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0	0.6257	21.2	17.7
820	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	0	0.4984	18.1	15.1
821	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	1	0.4984	18.1	15.1
822	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	0	0.4984	18.1	15.1
823	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	3	1.6523	36.5	30.4
824	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1	0.4984	18.1	15.1
825	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	0	0.4984	18.1	15.1
826	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	0	0.8659	24.5	20.4
827	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	1	0.8659	24.5	20.4
828	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	0	0.8659	24.5	20.4
829	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	7	1.6523	36.5	30.4
830	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	0	1.6523	36.5	30.4
834	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	23	0.8659	24.5	20.4
835	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	12	0.8659	24.5	20.4
836	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1	0.6257	21.2	17.7
837	837	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	0	1.4182	29.1	24.3
838	837	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	0	1.2988	28.6	23.8
839	837	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	0	1.2988	28.6	23.8
840	840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	92	0.8876	22.1	18.4
841	840	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	38	0.6709	18.8	15.7
842	840	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	4	0.4984	18.1	15.1
843	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	7	0.8659	24.5	20.4
844	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	7	0.8659	24.5	20.4
845	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	1	0.4984	18.1	15.1
846	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	57	1.4182	29.1	24.3
847	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	54	1.2988	28.6	23.8
848	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0	1.2988	28.6	23.8
849	849	RADIOTHERAPY	119	0.7715	22.7	18.9
853	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	1,067	1.7465	37.7	31.4
854	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	96	1.1070	30.2	25.2
855	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	2	0.8659	24.5	20.4
856	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	364	1.4573	34.2	28.5
857	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	196	1.0392	30.4	25.3
858	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	10	0.8659	24.5	20.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
862	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1,721	0.9638	25.3	21.1
863	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1,030	0.6957	23.0	19.2
864	864	FEVER	3	0.4984	18.1	15.1
865	865	VIRAL ILLNESS W MCC	26	0.7995	21.3	17.8
866	865	VIRAL ILLNESS W/O MCC*	13	0.7995	21.3	17.8
867	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	451	1.0462	23.9	19.9
868	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	65	0.6851	19.6	16.3
869	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	2	0.4984	18.1	15.1
870	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	1,287	2.1384	31.7	26.4
871	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	5,887	0.8713	23.1	19.3
872	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,279	0.6232	20.3	16.9
876	876	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3	1.6523	36.5	30.4
880	880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	9	0.6257	21.2	17.7
881	881	DEPRESSIVE NEUROSES	34	0.3897	21.9	18.3
882	882	NEUROSES EXCEPT DEPRESSIVE	11	0.6257	21.2	17.7
883	883	DISORDERS OF PERSONALITY & IMPULSE CONTROL	7	0.6257	21.2	17.7
884	884	ORGANIC DISTURBANCES & MENTAL RETARDATION	78	0.5222	26.1	21.8
885	885	PSYCHOSES	876	0.3974	24.1	20.1
886	886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	38	0.4203	24.7	20.6
887	887	OTHER MENTAL DISORDER DIAGNOSES	2	0.4984	18.1	15.1
894	894	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0	0.4984	18.1	15.1
895	895	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0	0.4984	18.1	15.1
896	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	12	0.8659	24.5	20.4
897	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	8	0.4984	18.1	15.1
901	901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	293	1.3963	34.5	28.8
902	901	WOUND DEBRIDEMENTS FOR INJURIES W CC	138	1.0375	29.9	24.9
903	901	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	6	0.6257	21.2	17.7
904	904	SKIN GRAFTS FOR INJURIES W CC/MCC	100	1.3712	38.3	31.9
905	904	SKIN GRAFTS FOR INJURIES W/O CC/MCC	2	0.6257	21.2	17.7
906	906	HAND PROCEDURES FOR INJURIES	3	0.6257	21.2	17.7
907	907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	135	1.4541	34.3	28.6
908	907	OTHER O.R. PROCEDURES FOR INJURIES W CC	58	0.9494	28.8	24.0
909	907	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	4	0.6257	21.2	17.7
913	913	TRAUMATIC INJURY W MCC	49	0.7638	24.3	20.3
914	913	TRAUMATIC INJURY W/O MCC	79	0.5669	20.1	16.8
915	915	ALLERGIC REACTIONS W MCC	1	0.4984	18.1	15.1
916	915	ALLERGIC REACTIONS W/O MCC	0	0.4984	18.1	15.1
917	917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	8	1.0928	29.1	24.3
918	917	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	3	0.4984	18.1	15.1
919	919	COMPLICATIONS OF TREATMENT W MCC	1,544	1.0986	26.8	22.3
920	919	COMPLICATIONS OF TREATMENT W CC	889	0.8185	25.0	20.8
921	919	COMPLICATIONS OF TREATMENT W/O CC/MCC	53	0.5129	18.4	15.3
922	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	7	0.8659	24.5	20.4
923	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	11	0.4984	18.1	15.1
927	927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	0	0.8659	24.5	20.4
928	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	11	0.8659	24.5	20.4
929	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC*	1	0.8659	24.5	20.4
933	933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	11	0.6257	21.2	17.7
934	934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	31	0.6443	23.9	19.9
935	935	NON-EXTENSIVE BURNS	64	0.6788	22.2	18.5
939	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	225	1.3992	33.6	28.0
940	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	98	1.0055	31.1	25.9
941	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	9	0.6257	21.2	17.7
945	945	REHABILITATION W CC/MCC	1,346	0.6478	21.2	17.7
946	945	REHABILITATION W/O CC/MCC	90	0.4103	17.3	14.4
947	947	SIGNS & SYMPTOMS W MCC	41	0.8195	23.5	19.6
948	947	SIGNS & SYMPTOMS W/O MCC	52	0.4818	19.9	16.6

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
949	949	AFTERCARE W CC/MCC	3,267	0.7119	22.0	18.3
950	949	AFTERCARE W/O CC/MCC	197	0.4441	17.0	14.2
951	951	OTHER FACTORS INFLUENCING HEALTH STATUS	66	1.5162	27.2	22.7
955	955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.0928	29.1	24.3
956	956	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.6523	36.5	30.4
957	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	1	0.6257	21.2	17.7
958	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	0	0.6257	21.2	17.7
959	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0	0.6257	21.2	17.7
963	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	9	1.0928	29.1	24.3
964	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	8	1.0928	29.1	24.3
965	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1	0.4984	18.1	15.1
969	969	HIV W EXTENSIVE O.R. PROCEDURE W MCC	12	1.6523	36.5	30.4
970	969	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2	0.8659	24.5	20.4
974	974	HIV W MAJOR RELATED CONDITION W MCC	212	1.0484	23.2	19.3
975	974	HIV W MAJOR RELATED CONDITION W CC	59	0.6735	19.3	16.1
976	974	HIV W MAJOR RELATED CONDITION W/O CC/MCC	7	0.4984	18.1	15.1
977	977	HIV W OR W/O OTHER RELATED CONDITION	31	0.6830	20.3	16.9
981	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	1,050	2.2095	41.8	34.8
982	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	218	1.1252	30.7	25.6
983	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	6	0.6257	21.2	17.7
984	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	19	1.6523	36.5	30.4
985	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	8	1.0928	29.1	24.3
986	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	0	1.0928	29.1	24.3
987	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	468	1.8365	38.5	32.1
988	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	172	1.0367	30.3	25.3
989	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	4	0.6257	21.2	17.7
998	998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	0.0000	0.0	0.0
999	999	UNGROUPABLE	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529(a) in conjunction with §412.503).

* In determining the MS-LTC-DRG relative weights for FY 2011, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section VII.B.3.g. (step 6) of the preamble of this final rule.

TABLE 12A.— LTCH PPS WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
10180	Abilene, TX	
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	0.8003
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	0.3471
10420	Akron, OH	
	Portage County, OH	
	Summit County, OH	0.8843
10500	Albany, GA	
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	0.9036
10580	Albany-Schenectady-Troy, NY	
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	0.8653

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
10740	Albuquerque, NM	
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	0.9456
10780	Alexandria, LA	
	Grant Parish, LA	
	Rapides Parish, LA	0.7995
10900	Allentown-Bethlehem-Easton, PA-NJ	
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	0.9194
11020	Altoona, PA	
	Blair County, PA	0.8620
11100	Amarillo, TX	
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	0.8644
11180	Ames, IA	
	Story County, IA	0.9970
11260	Anchorage, AK	
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	1.1964
11300	Anderson, IN	
	Madison County, IN	0.9192
11340	Anderson, SC	
	Anderson County, SC	0.8691
11460	Ann Arbor, MI	
	Washtenaw County, MI	1.0124
11500	Anniston-Oxford, AL	
	Calhoun County, AL	0.7918
11540	Appleton, WI	
	Calumet County, WI	
	Outagamie County, WI	0.9361
11700	Asheville, NC	
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	0.9001
12020	Athens-Clarke County, GA	
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	0.9659
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	0.9549
12100	Atlantic City, NJ- Hammonton, New Jersey	
	Atlantic County, NJ	1.1129
12220	Auburn-Opelika, AL	
	Lee County, AL	0.7190
12260	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	0.9538
12420	Austin-Round Rock-San Marcos, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	0.9514

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
12540	Bakersfield-Delano, CA	
	Kern County, CA	1.1707
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	1.0255
12620	Bangor, ME	
	Penobscot County, ME	0.9777
12700	Barnstable Town, MA	
	Barnstable County, MA	1.2823
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	0.8583
12980	Battle Creek, MI	
	Calhoun County, MI	0.9656
13020	Bay City, MI	
	Bay County, MI	0.9221
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	0.8488
13380	Bellingham, WA	
	Whatcom County, WA	1.1390
13460	Bend, OR	
	Deschutes County, OR	1.1372
13644	Bethesda- - Rockville-Frederick, MD	
	Frederick County, MD	
	Montgomery County, MD	1.0525
13740	Billings, MT	
	Carbon County, MT	
	Yellowstone County, MT	0.8674
13780	Binghamton, NY	
	Broome County, NY	
	Tioga County, NY	0.8719
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	0.8611
13900	Bismarck, ND	
	Burleigh County, ND	
	Morton County, ND	0.7348
13980	Blacksburg-Christiansburg-Radford, VA	
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	0.8314
14020	Bloomington, IN	
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	0.8989
14060	Bloomington-Normal, IL	
	McLean County, IL	0.9439
14260	Boise City-Nampa, ID	
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	0.9273
14484	Boston-Quincy, MA	
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	1.2178
14500	Boulder, CO	
	Boulder County, CO	1.0065
14540	Bowling Green, KY	
	Edmonson County, KY	
	Warren County, KY	0.8666
14740	Bremerton-Silverdale, WA	
	Kitsap County, WA	1.0667
14860	Bridgeport-Stamford-Norwalk, CT	
	Fairfield County, CT	1.2547
15180	Brownsville-Harlingen, TX	
	Cameron County, TX	0.9173

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
15260	Brunswick, GA	
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	0.9209
15380	Buffalo-Niagara Falls, NY	
	Erie County, NY	
	Niagara County, NY	0.9530
15500	Burlington, NC	
	Alamance County, NC	0.8863
15540	Burlington-South Burlington, VT	
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	0.9947
15764	Cambridge-Newton-Framingham, MA	
	Middlesex County, MA	1.1250
15804	Camden, NJ	
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	1.0386
15940	Canton-Massillon, OH	
	Carroll County, OH	
	Stark County, OH	0.8749
15980	Cape Coral-Fort Myers, FL	
	Lee County, FL	0.9195
16020	Cape Girardeau-Jackson, MO-IL	
	Alexander County, IL	
	Bollinger County, MO	
	Cape Girardeau County, MO	0.8983
16180	Carson City, NV	
	Carson City, NV	1.0465
16220	Casper, WY	
	Natrona County, WY	0.9655
16300	Cedar Rapids, IA	
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	0.8844
16580	Champaign-Urbana, IL	
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	1.0235
16620	Charleston, WV	
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	0.7895
16700	Charleston-North CharlestonSummerville, SC	
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	0.9354
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	0.9420
16820	Charlottesville, VA	
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	0.9342
16860	Chattanooga, TN-GA	
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	0.8829
16940	Cheyenne, WY	
	Laramie County, WY	0.9392
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	1.0593
17020	Chico, CA	
	Butte County, CA	1.1533

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
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	0.9699
17300	Clarksville, TN-KY	
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	0.7888
17420	Cleveland, TN	
	Bradley County, TN	
	Polk County, TN	0.7731
17460	Cleveland-Elyria-Mentor, OH	
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	0.9050
17660	Coeur d'Alene, ID	
	Kootenai County, ID	0.9364
17780	College Station-Bryan, TX	
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	0.9588
17820	Colorado Springs, CO	
	El Paso County, CO	
	Teller County, CO	0.9481
17860	Columbia, MO	
	Boone County, MO	
	Howard County, MO	0.8282
17900	Columbia, SC	
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	0.8733
17980	Columbus, GA-AL	
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	0.9027
18020	Columbus, IN	
	Bartholomew County, IN	0.9434
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	1.0141
18580	Corpus Christi, TX	
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	0.8585
18700	Corvallis, OR	
	Benton County, OR	1.0455
18880	Crestview-Fort Walton Beach- Destin, FL	
	Okaloosa County, FL	0.8842
19060	Cumberland, MD-WV	
	Allegany County, MD	
	Mineral County, WV	0.8186
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	0.9860

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
19140	Dalton, GA	
	Murray County, GA	
	Whitfield County, GA	0.8622
19180	Danville, IL	
	Vermilion County, IL	0.9693
19260	Danville, VA	
	Pittsylvania County, VA	
	Danville City, VA	0.8168
19340	Davenport-Moline-Rock Island, IA-IL	
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	0.8400
19380	Dayton, OH	
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	0.9140
19460	Decatur, AL	
	Lawrence County, AL	
	Morgan County, AL	0.7621
19500	Decatur, IL	
	Macon County, IL	0.7916
19660	Deltona-Daytona Beach-Ormond Beach, FL	
	Volusia County, FL	0.8736
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	1.0718
19780	Des Moines,-West Des Moines, IA	
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	0.9621
19804	Detroit-Livonia-Dearborn, MI	
	Wayne County, MI	0.9699
20020	Dothan, AL	
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	0.7435
20100	Dover, DE	
	Kent County, DE	0.9921
20220	Dubuque, IA	
	Dubuque County, IA	0.8774
20260	Duluth, MN-WI	
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	1.0565
20500	Durham-Chapel Hill, NC	
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	0.9664
20740	Eau Claire, WI	
	Chippewa County, WI	
	Eau Claire County, WI	0.9639
20764	Edison-New Brunswick, NJ	
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	1.1006
20940	El Centro, CA	
	Imperial County, CA	0.9258
21060	Elizabethtown, KY	
	Hardin County, KY	
	Larue County, KY	0.8449
21140	Elkhart-Goshen, IN	
	Elkhart County, IN	0.9465
21300	Elmira, NY	
	Chemung County, NY	0.8445
21340	El Paso, TX	
	El Paso County, TX	0.8475
21500	Erie, PA	
	Erie County, PA	0.8360
21660	Eugene-Springfield, OR	
	Lane County, OR	1.1384

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8433
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1080
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3883
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8064
22140	Farmington, NM San Juan County, NM	0.9339
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9323
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8616
22380	Flagstaff, AZ Coconino County, AZ	1.2443
22420	Flint, MI Genesee County, MI	1.1496
22500	Florence, SC Darlington County, SC Florence County, SC	0.8252
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8144
22540	Fond du Lac, WI Fond du Lac County, WI	0.9223
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9892
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7599
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9362
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9474
23420	Fresno, CA Fresno County, CA	1.1422
23460	Gadsden, AL Etowah County, AL	0.7180
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9160
23580	Gainesville, GA Hall County, GA	0.9223
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9084
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8507
24140	Goldsboro, NC Wayne County, NC	0.9067
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7717
24300	Grand Junction, CO Mesa County, CO	0.9850
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9169
24500	Great Falls, MT Cascade County, MT	0.8289

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
24540	Greeley, CO	
	Weld County, CO	0.9496
24580	Green Bay, WI	
	Brown County, WI	
	Kewaunee County, WI	
	Oconto County, WI	0.9586
24660	Greensboro-High Point, NC	
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	0.8882
24780	Greenville, NC	
	Greene County, NC	
	Pitt County, NC	0.9370
24860	Greenville-Mauldin-Easley, SC	
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	0.9644
25020	Guayama, PR	
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	0.3686
25060	Gulfport-Biloxi, MS	
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	0.8877
25180	Hagerstown-Martinsburg, MD-WV	
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	0.9254
25260	Hanford-Corcoran, CA	
	Kings County, CA	1.1205
25420	Harrisburg-Carlisle, PA	
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	0.9296
25500	Harrisonburg, VA	
	Rockingham County, VA	
	Harrisonburg City, VA	0.9158
25540	Hartford-West Hartford-East Hartford, CT	
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	1.0927
25620	Hattiesburg, MS	
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	0.7714
25860	Hickory-Lenoir-Morganton, NC	
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	0.8693
25980	Hinesville-Fort Stewart, GA	
	Liberty County, GA	
	Long County, GA	0.8958
26100	Holland-Grand Haven, MI	
	Ottawa County, MI	0.8632
26180	Honolulu, HI	
	Honolulu County, HI	1.1807
26300	Hot Springs, AR	
	Garland County, AR	0.9151
26380	Houma-Bayou Cane-Thibodaux, LA	
	Lafourche Parish, LA	
	Terrebonne Parish, LA	0.7852
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	0.9824
26580	Huntington-Ashland, WV-KY-OH	
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	0.8953
26620	Huntsville, AL	
	Limestone County, AL	
	Madison County, AL	0.9191
26820	Idaho Falls, ID	
	Bonneville County, ID	
	Jefferson County, ID	0.9663

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
26900	Indianapolis-Carmel, IN	
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	0.9672
26980	Iowa City, IA	
	Johnson County, IA	
	Washington County, IA	0.9657
27060	Ithaca, NY	
	Tompkins County, NY	0.9842
27100	Jackson, MI	
	Jackson County, MI	0.9155
27140	Jackson, MS	
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	0.8042
27180	Jackson, TN	
	Chester County, TN	
	Madison County, TN	0.8404
27260	Jacksonville, FL	
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	0.8884
27340	Jacksonville, NC	
	Onslow County, NC	0.7807
27500	Janesville, WI	
	Rock County, WI	0.9415
27620	Jefferson City, MO	
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	0.8434
27740	Johnson City, TN	
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	0.8105
27780	Johnstown, PA	
	Cambria County, PA	0.8090
27860	Jonesboro, AR	
	Craighead County, AR	
	Poinsett County, AR	0.7757
27900	Joplin, MO	
	Jasper County, MO	
	Newton County, MO	0.8214
28020	Kalamazoo-Portage, MI	
	Kalamazoo County, MI	
	Van Buren County, MI	1.0292
28100	Kankakee-Bradley, IL	
	Kankakee County, IL	1.0619
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	0.9652
28420	Kennewick- Pasco-Richland, WA	
	Benton County, WA	
	Franklin County, WA	0.9976
28660	Killeen-Temple-Fort Hood, TX	
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	0.8798
28700	Kingsport-Bristol-Bristol, TN-VA	
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	0.7588
28740	Kingston, NY	
	Ulster County, NY	0.9075

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7842
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9130
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9803
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9289
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8489
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8196
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0781
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0235
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8447
29540	Lancaster, PA Lancaster County, PA	0.9344
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0298
29700	Laredo, TX Webb County, TX	0.7914
29740	Las Cruces, NM Dona Ana County, NM	0.9296
29820	Las Vegas-Paradise, NV Clark County, NV	1.2099
29940	Lawrence, KS Douglas County, KS	0.8533
30020	Lawton, OK Comanche County, OK	0.8285
30140	Lebanon, PA Lebanon County, PA	0.7807
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9358
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8903
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8817
30620	Lima, OH Allen County, OH	0.9271
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9617
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	0.8546
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8794
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8563
31020	Longview, WA Cowlitz County, WA	1.0296
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2130

CBSA Code	Urban Area (Constituent Counties)	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	0.8896
31180	Lubbock, TX	
	Crosby County, TX	
	Lubbock County, TX	0.8847
31340	Lynchburg, VA	
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	0.8694
31420	Macon, GA	
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	0.9202
31460	Madera-Chowchilla, CA	
	Madera County, CA	0.7986
31540	Madison, WI	
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	1.1294
31700	Manchester-Nashua, NH	
	Hillsborough County, NH	0.9869
31740	Mahattan, KS	
	Geary County, KS	
	Pottawatomie County, KS	
	Riley County; KS	0.7847
31860	Mankato-North Mankato, MN	
	Blue Earth County, MN	
	Nicollet County, MN	0.9083
31900	Mansfield, OH	
	Richland County, OH	0.8918
32420	Mayagüez, PR	
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	0.3640
32580	McAllen-Edinburg-Mission, TX	
	Hidalgo County, TX	0.8837
32780	Medford, OR	
	Jackson County, OR	1.0061
32820	Memphis, TN-MS-AR	
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	0.9268
32900	Merced, CA	
	Merced County, CA	1.2359
33124	Miami-Miami Beach-Kendall, FL	
	Miami-Dade County, FL	1.0128
33140	Michigan City-La Porte, IN	
	LaPorte County, IN	0.9470
33260	Midland, TX	
	Midland County, TX	0.9711
33340	Milwaukee-Waukesha-West Allis, WI	
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	1.0183
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	1.1143

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
33540	Missoula, MT	
	Missoula County, MT	0.8921
33660	Mobile, AL	
	Mobile County, AL	0.7960
33700	Modesto, CA	
	Stanislaus County, CA	1.2104
33740	Monroe, LA	
	Ouachita Parish, LA	
	Union Parish, LA	0.7993
33780	Monroe, MI	
	Monroe County, MI	0.8684
33860	Montgomery, AL	
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	0.8442
34060	Morgantown, WV	
	Monongalia County, WV	
	Preston County, WV	0.8137
34100	Morristown, TN	
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	0.7041
34580	Mount Vernon-Anacortes, WA	
	Skagit County, WA	1.0363
34620	Muncie, IN	
	Delaware County, IN	0.8206
34740	Muskegon-Norton Shores, MI	
	Muskegon County, MI	0.9809
34820	Myrtle Beach- North Myrtle Beach-Conway, SC	
	Horry County, SC	0.8738
34900	Napa, CA	
	Napa County, CA	1.4604
34940	Naples-Marco Island, FL	
	Collier County, FL	0.9698
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	0.9457
35004	Nassau-Suffolk, NY	
	Nassau County, NY	
	Suffolk County, NY	1.2315
35084	Newark-Union, NJ-PA	
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	1.1460
35300	New Haven-Milford, CT	
	New Haven County, CT	1.1515
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	0.9070
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	1.2955

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
35660	Niles-Benton Harbor, MI	
	Berrien County, MI	0.8872
35840	North Port-Bradenton-Sarasota, FL	
	Manatee County, FL	
	Sarasota County, FL	0.9481
35980	Norwich-New London, CT	
	New London County, CT	1.1215
36084	Oakland-Fremont-Hayward, CA	
	Alameda County, CA	
	Contra Costa County, CA	1.6354
36100	Ocala, FL	
	Marion County, FL	0.8468
36140	Ocean City, NJ	
	Cape May County, NJ	1.0879
36220	Odessa, TX	
	Ector County, TX	0.9436
36260	Ogden-Clearfield, UT	
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	0.9267
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	0.8877
36500	Olympia, WA	
	Thurston County, WA	1.1269
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	0.9583
36740	Orlando-Kissimmee-Sanford, FL	
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	0.9163
36780	Oshkosh-Neenah, WI	
	Winnebago County, WI	0.9566
36980	Owensboro, KY	
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	0.8370
37100	Oxnard-Thousand Oaks-Ventura, CA	
	Ventura County, CA	1.2377
37340	Palm Bay-Melbourne-Titusville, FL	
	Brevard County, FL	0.9211
	Palm Coast, FL	
37380	Flager County, FL	0.8405
37460	Panama City-Lynn Haven-Panama City Beach, FL	
	Bay County, FL	0.7954
37620	Parkersburg-Marietta-Vienna, WV-OH	
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	0.7455
37700	Pascagoula, MS	
	George County, MS	
	Jackson County, MS	0.8299
	Peabody, MA	
37764	Essex County, MA	1.0979
37860	Pensacola-Ferry Pass-Brent, FL	
	Escambia County, FL	
	Santa Rosa County, FL	0.8254
37900	Peoria, IL	
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	0.9149
37964	Philadelphia, PA	
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	1.0803
38060	Phoenix-Mesa-Glendale, AZ	
	Maricopa County, AZ	
	Pinal County, AZ	1.0642
38220	Pine Bluff, AR	
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	0.8012

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
38300	Pittsburgh, PA	
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	0.8605
38340	Pittsfield, MA	
	Berkshire County, MA	1.0371
38540	Pocatello, ID	
	Bannock County, ID	
	Power County, ID	0.9507
38660	Ponce, PR	
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	0.4326
38860	Portland-South Portland-Biddeford, ME	
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	0.9899
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	1.1476
38940	Port St. Lucie, FL	
	Martin County, FL	
	St. Lucie County, FL	1.0723
39100	Poughkeepsie-Newburgh-Middletown, NY	
	Dutchess County, NY	
	Orange County, NY	1.1354
39140	Prescott, AZ	
	Yavapai County, AZ	1.2234
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	1.0714
39340	Provo-Orem, UT	
	Juab County, UT	
	Utah County, UT	0.9321
39380	Pueblo, CO	
	Pueblo County, CO	0.8721
39460	Punta Gorda, FL	
	Charlotte County, FL	0.8759
39540	Racine, WI	
	Racine County, WI	1.0580
39580	Raleigh-Cary, NC	
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	0.9811
39660	Rapid City, SD	
	Meade County, SD	
	Pennington County, SD	1.0442
39740	Reading, PA	
	Berks County, PA	0.8904
39820	Redding, CA	
	Shasta County, CA	1.4134
39900	Reno-Sparks, NV	
	Storey County, NV	
	Washoe County, NV	1.0419
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	0.9661

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
40140	Riverside-San Bernardino-Ontario, CA	
	Riverside County, CA	
	San Bernardino County, CA	1.1570
40220	Roanoke, VA	
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	0.8827
40340	Rochester, MN	
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	1.0942
40380	Rochester, NY	
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	0.8595
40420	Rockford, IL	
	Boone County, IL	
	Winnebago County, IL	1.0033
40484	Rockingham County-Strafford County, NH	
	Rockingham County, NH	
	Strafford County, NH	1.0026
40580	Rocky Mount, NC	
	Edgecombe County, NC	
	Nash County, NC	0.9034
40660	Rome, GA	
	Floyd County, GA	0.8635
40900	Sacramento--Arden-Arcade--Roseville, CA	
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	1.4053
40980	Saginaw-Saginaw Township North, MI	
	Saginaw County, MI	0.8728
41060	St. Cloud, MN	
	Benton County, MN	
	Stearns County, MN	1.1042
41100	St. George, UT	
	Washington County, UT	0.9133
41140	St. Joseph, MO-KS	
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	1.0302
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	0.9090
41420	Salem, OR	
	Marion County, OR	
	Polk County, OR	1.1133
41500	Salinas, CA	
	Monterey County, CA	1.5686
41540	Salisbury, MD	
	Somerset County, MD	
	Wicomico County, MD	0.9005
41620	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	0.9266
41660	San Angelo, TX	
	Irion County, TX	
	Tom Green County, TX	0.8303

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
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	0.8998
41740	San Diego-Carlsbad-San Marcos, CA	
	San Diego County, CA	1.1979
41780	Sandusky, OH	
	Erie County, OH	0.8686
41884	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	1.5733
41900	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	0.4560
41940	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
	Santa Clara County, CA	1.6703
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	0.4296
42020	San Luis Obispo-Paso Robles, CA	
	San Luis Obispo County, CA	1.2915
42044	Santa Ana-Anaheim-Irvine, CA	
	Orange County, CA	1.2162

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
42060	Santa Barbara-Santa Maria-Goleta, CA	
	Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA	
	Santa Cruz County, CA	1.6740
42140	Santa Fe, NM	
	Santa Fe County, NM	1.0847
42220	Santa Rosa-Petaluma, CA	
	Sonoma County, CA	1.6143
42340	Savannah, GA	
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	0.8907
42540	Scranton--Wilkes-Barre, PA	
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	0.8238
42644	Seattle-Tacoma-Bellevue, WA	
	King County, WA	
	Snohomish County, WA	1.1556
42680	Sebastian-Vero Beach, FL	
	Indian River County, FL	0.9097
43100	Sheboygan, WI	
	Sheboygan County, WI	0.9233
43300	Sherman-Denison, TX	
	Grayson County, TX	0.8279
43340	Shreveport-Bossier City, LA	
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	0.8536
43580	Sioux City, IA-NE-SD	
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	0.9091
43620	Sioux Falls, SD	
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	0.9299
43780	South Bend-Mishawaka, IN-MI	
	St. Joseph County, IN	
	Cass County, MI	0.9948
43900	Spartanburg, SC	
	Spartanburg County, SC	0.9383
44060	Spokane, WA	
	Spokane County, WA	1.0571
44100	Springfield, IL	
	Menard County, IL	
	Sangamon County, IL	0.9130
44140	Springfield, MA	
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	1.0251
44180	Springfield, MO	
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	0.8371
44220	Springfield, OH	
	Clark County, OH	0.9234
44300	State College, PA	
	Centre County, PA	0.8779
44600	SteubenvilleWeirton-, WV-OH	
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	0.7315
44700	Stockton, CA	
	San Joaquin County, CA	1.2644
44940	Sumter, SC	
	Sumter County, SC	0.7860
45060	Syracuse, NY	
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	0.9905
45104	Tacoma, WA	
	Pierce County, WA	1.1343
45220	Tallahassee, FL	
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	0.8806
45300	Tampa-St. Petersburg-Clearwater, FL	
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	0.9054
45460	Terre Haute, IN	
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	0.9205

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
45500	Texarkana, TX-Texarkana, AR	
	Miller County, AR	
	Bowie County, TX	0.7748
45780	Toledo, OH	
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	0.9432
45820	Topeka, KS	
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	0.8952
45940	Trenton-Ewing, NJ	
	Mercer County, NJ	1.0150
46060	Tucson, AZ	
	Pima County, AZ	0.9480
46140	Tulsa, OK	
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	0.8793
46220	Tuscaloosa, AL	
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	0.8843
46340	Tyler, TX	
	Smith County, TX	0.8065
46540	Utica-Rome, NY	
	Herkimer County, NY	
	Oneida County, NY	0.8471
46660	Valdosta, GA	
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	0.7941
46700	Vallejo-Fairfield, CA	
	Solano County, CA	1.4931
47020	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	0.8219
47220	Vineland-Millville-Bridgeton, NJ	
	Cumberland County, NJ	1.0534
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	0.8961
47300	Visalia-Porterville, CA	
	Tulare County, CA	1.0738
47380	Waco, TX	
	McLennan County, TX	0.8403
47580	Warner Robins, GA	
	Houston County, GA	0.8028
47644	Warren-Troy-Farmington Hills, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	0.9648

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
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	1.0723
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8462
48140	Wausau, WI Marathon County, WI	0.9563
48300	Wenatchee- East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9615
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9934
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6675
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8898
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9566
48700	Williamsport, PA Lycoming County, PA	0.7256
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0580
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9202
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0002
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8939
49340	Worcester, MA Worcester County, MA	1.1012
49420	Yakima, WA Yakima County, WA	1.0067
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3536
49620	York-Hanover, PA York County, PA	0.9983
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8625
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1043
49740	Yuma, AZ Yuma County, AZ	0.9283

CBSA Code	Nonurban Area	LTCH PPS Wage Index
01	Alabama	0.7380
02	Alaska	1.2626
03	Arizona	0.9095
04	Arkansas	0.7222
05	California	1.2056
06	Colorado	0.9933
07	Connecticut	1.1128
08	Delaware	0.9757
10	Florida	0.8409
11	Georgia	0.7566
12	Hawaii	1.1189
13	Idaho	0.7556
14	Illinois	0.8343
15	Indiana	0.8391
16	Iowa	0.8545
17	Kansas	0.7981
18	Kentucky	0.7830
19	Louisiana	0.7712
20	Maine	0.8588
21	Maryland	0.9175
22	Massachusetts	1.1769
23	Michigan	0.8555
24	Minnesota	0.9038
25	Mississippi	0.7620
26	Missouri	0.7655
27	Montana	0.8517
28	Nebraska	0.8911
29	Nevada	0.9350
30	New Hampshire	1.0207
31	New Jersey*	--------
32	New Mexico	0.8911
33	New York	0.8185
34	North Carolina	0.8359
35	North Dakota	0.6831
36	Ohio	0.8561
37	Oklahoma	0.7860
38	Oregon	1.0029
39	Pennsylvania	0.8480
41	Rhode Island*	--------
42	South Carolina	0.8413
43	South Dakota	0.8536
44	Tennessee	0.7886
45	Texas	0.7806
46	Utah	0.8649

TABLE 12B.— LTCH PPS WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Nonurban Area	LTCH PPS Wage Index
47	Vermont	0.9591
49	Virginia	0.7841
50	Washington	1.0184
51	West Virginia	0.7474
52	Wisconsin	0.9186
53	Wyoming	0.9528

*All counties within the State are classified as urban.

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Note: The following Appendices will not appear in the Code of Federal Regulations.

Appendix A: Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the final changes for FY 2011 acute care hospital operating and capital payments will redistribute amounts in excess of $100 million among different types of inpatient cases. The final applicable percentage increase to the IPPS rates required by the statute, in conjunction with other final payment changes in this final rule, will result in an estimated $440 million decrease in FY 2011 operating payments (or −0.4 percent decrease) and an estimated $21 million decrease in FY 2011 capital payments (or −0.5 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 $22.3 million (or 0.5 percent).

Our operating impact estimate includes the final −2.9 percent documentation and coding adjustment applied to the hospital-specific rates, the final −2.6 percent documentation and coding adjustment applied to the Puerto Rico-specific rates and the final −2.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts. In addition, our operating impact estimate includes the final 2.35 percent market basket update to the standardized amount (which includes the final 2.6 percent update with the 0.25 percentage point reduction required under the Affordable Care Act). 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/table/index.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that the provisions of this final rule relating to acute care hospitals would have a significant impact on small entities as explained in this Appendix. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we are assuming that all LTCHs are considered small entities for the purpose of the analysis in section IX. of this Appendix. Medicare fiscal intermediaries and MACs are not considered to be small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule constitutes our final regulatory flexibility analysis. Therefore, in the FY 2011 IPPS/LTCH PPS proposed rule and the supplemental proposed rule (75 FR 24287 and 31093, respectively), we solicited public comments on our estimates and analysis of the impact of our proposals on those small entities. We address any public comments that we received on the impact of the changes that we are finalizing in the applicable sections of this Appendix.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28, requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this final rule are available on the CMS IPPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. We also note that the Hospital Center Web page at *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table 1 and section VI. of this Appendix for the quantitative effects of the final policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This final rule 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 final 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 final rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The final rule 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 changes in this final 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 finalized 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 finalized 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.

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 June 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 also are approximately 1,317 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 final policy changes.) There are also 1,260 IPPS-excluded hospitals and 2,150 IPPS-excluded hospital units. These IPPS-excluded hospitals and units include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these IPPS-excluded hospitals and units are not included in this final rule. The impact of the final 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 June 2010, there were 3,415 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, 230 rehabilitation hospitals and 953 rehabilitation units, and 433 LTCHs, are paid the Federal prospective per discharge rate under the IRF PPS and the LTCH PPS, respectively, and 507 psychiatric hospitals and 1,197 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 discussed in this final 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 second quarter forecast, with historical data through the 2010 first quarter, the final FY 2011 update to the IPPS operating market basket is 2.6 percent (that is, the current estimate of the market basket rate-of-increase). However, the Affordable Care Act requires a 0.25 percentage point reduction to the market basket update resulting in a final 2.35 percent applicable percentage increase for IPPS hospitals. RNCHIs, children's hospitals and cancer hospitals are not subject to the reduction in the applicable percentage increase required under the Affordable Care Act. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40. Therefore, for RNHCIs, the final update is the same as for children's and cancer hospitals, which is the percentage increase in the FY 2011 IPPS operating market basket, estimated to be 2.6 percent, without the reductions required under the Affordable Care Act.

The impact of the final 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 and whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, cancer and children's hospitals can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing final 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 0.4 percent compared to FY 2010, largely due to the documentation and coding adjustments and the applicable percentage increase applied to the IPPS rates. This amount reflects the FY 2011 documentation and coding adjustments described in Section X of this final rule: −2.9 percent for the IPPS national standardized amounts, −2.9 percent for the IPPS hospital-specific rates, and −2.6 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 finalized changes to each system. This section deals with changes to the operating inpatient prospective payment system for acute care hospitals. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this final rule. However, there are other finalized changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those finalized 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 final changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost reports 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 data sources 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 the 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.

We discuss the following changes below:

- The effects of the annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based MS–DRG relative weights.
- The effects of the changes in hospitals' wage index values reflecting updated 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 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 frontier wage index provision that requires that hospitals located in States that qualify as frontier states cannot have a wage index less than 1.0. This provision is not budget neutral.
- The effects of the rural floor and imputed floor with a national budget neutrality applied to the wage index, as required by the Affordable Care Act.
- The effects of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total estimated change in payments based on the FY 2011 policies relative to payments based on FY 2010 policies that include the applicable percentage increase of 2.35 percent (or 2.6 percent market basket with a 0.25 percentage point reduction, as required under the Affordable Care Act). The FY 2010 operating payments also account for provisions under the Affordable Care Act that were effective for FY 2010.

To illustrate the impact of the FY 2011 changes, our analysis begins with a FY 2010 baseline simulation model using: The FY 2011 applicable percentage increase of 2.35 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, as amended by section 4102(b)(1)(A) of the ARRA (Pub. L. 111–5) and by section 3401(a)(2) of the Affordable Care Act (Pub. L. 111–148), provides that, for FY 2007 through FY 2014, 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. (Beginning in FY 2015, the reduction is one-quarter of such applicable percentage increase determined without regard to section 1886(b)(3)(B)(ix), (xi), or (xii) of the Act.) 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 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 change.

Our final comparison illustrates the 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 updating the standardized amounts for FY 2011 using an applicable percentage increase of 2.35 percent. This includes our forecasted hospital market basket increase of 2.6 percent with a 0.25 percentage point reduction as required under the Affordable Care Act. (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 2.35 percent to 0.35 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 2.35 percent. In addition, we are updating the Puerto Rico specific amount by an applicable percentage increase of 2.35 percent.

A second significant factor that affects the changes in hospitals' payments per case from FY 2010 to FY 2011 is the change in hospitals' 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 2010 will be 4.7 percent of total MS–DRG payments. Our updated FY 2010 outlier estimate accounts for changes to the FY 2010 IPPS payments required under the Affordable Care Act. 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 lower 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 final 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 2,494 hospitals located in urban areas included in our analysis. Among these, there are 1,362 hospitals located in large urban areas (populations over 1 million), and 1,132 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 978 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 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 sections 1886(d)(8)(B) and 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,551; 1,404; 1,147; and 921, 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 2,429 nonteaching hospitals in our analysis, 805 teaching hospitals with fewer than 100 residents, and 238 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban or rural, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 180 RRCs, 332 SCHs, 194 MDHs, and 117 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. These groupings account for the change in the MGCRB reclassification policy as required under the Affordable Care Act.

The final category shows the impact of the policy changes on the 19 cardiac hospitals in our analysis.

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TABLE I.--IMPACT ANALYSIS OF FINAL CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2011

	No. of Hospitals[1]	FY 2011 Weights & MS-DRG Changes[2] (1)	Application of Recalibration Budget Neutrality[3] (2)	FY 2011 Wage Data[4] (3)	Application of Wage Budget Neutrality[5] (4)	Final FY 2011 MS-DRG, Relative Weights & Wage Index Changes, with Wage & Recalibration Budget Neutrality[6] (5)	FY 2011 MGCRB Reclassifications[7] (6)	Rural Floor Budget Neutrality and National Rural Floor Budget Neutrality[8] (7)	Application of the Frontier Wage Index[9] (8)	FY 2011 Out-Migration Adjustment[10] (9)	All FY 2011 Changes Prior to the CMI Adjustment (10)	All FY 2011 Changes w/CMI Adjustment[11] (11)
All Hospitals	3472	0.3	0	0	0	0	0	0	0	0	2.5	-0.4
By Geographic Location:												
Urban hospitals	2494	0.3	0	0	0	0	-0.2	0	0	0	2.4	-0.4
Large urban areas	1362	0.3	0	0	0	0	-0.3	0	0	0	2.4	-0.4
Other urban areas	1132	0.4	0	-0.1	-0.1	0	0	0.1	0.1	0	2.5	-0.4
Rural hospitals	978	0.4	0.1	0	0	0.1	1.7	-0.1	0	0.1	2.5	-0.4
Bed Size (Urban):												
0-99 beds	622	0.6	0.2	0.1	0.1	0.2	-0.5	0	0.1	0	2.6	-0.3
100-199 beds	785	0.2	-0.1	0	0	0	-0.1	0.2	0.1	0	2.4	-0.5
200-299 beds	460	0.3	0	0	0	0	0	0	0.1	0	2.4	-0.4
300-499 beds	430	0.3	0	0.1	0.1	0.1	-0.2	0	0.1	0	2.5	-0.4
500 or more beds	197	0.3	0	-0.1	-0.1	-0.1	-0.3	-0.1	0	0	2.5	-0.4
Bed Size (Rural):												
0-49 beds	348	0.8	0.4	0	0	0.5	0.6	-0.1	0.1	0.2	2.8	-0.1
50-99 beds	368	0.3	0	0	0	0	0.7	-0.1	0	0.1	2.2	-0.7
100-149 beds	156	0.4	0.1	0	0	0	2.3	-0.1	0	0	2.6	-0.3
150-199 beds	60	0.4	0.1	0	0	0.1	2.3	-0.1	0.1	0	2.6	-0.2
200 or more beds	46	0.1	-0.2	0.1	0.1	-0.1	2.6	-0.1	0	0	2.7	-0.2
Urban by Region:												
New England	121	0.1	-0.2	-0.5	-0.5	-0.7	0.8	0.8	0	0.2	2.2	-0.7
Middle Atlantic	330	0.3	0.1	-0.3	-0.3	-0.2	0.3	0.2	0	0	1.9	-0.9

	No. of Hospitals[1]	FY 2011 Weights & MS-DRG Changes[2] (1)	Application of Recalibration Budget Neutrality[3] (2)	FY 2011 Wage Data[4] (3)	Application of Wage Budget Neutrality[5] (4)	Final FY 2011 MS-DRG, Relative Weights & Wage Index Changes, with Wage & Recalibration Budget Neutrality[6] (5)	FY 2011 MGCRB Reclassifications[7] (6)	Rural Floor Budget Neutrality and National Rural Floor Budget Neutrality[8] (7)	Application of the Frontier Wage Index[9] (8)	FY 2011 Out-Migration Adjustment[10] (9)	All FY 2011 Changes Prior to the CMI Adjustment (10)	All FY 2011 Changes w/CMI Adjustment[11] (11)
South Atlantic	382	0.1	-0.2	0	0	-0.2	-0.4	-0.1	0	0	2.3	-0.6
East North Central	403	0.2	-0.1	0.2	0.2	0.1	-0.3	-0.2	0	0	2.2	-0.6
East South Central	155	0.4	0.1	-0.3	-0.3	-0.1	-0.2	0	0	0	2.4	-0.5
West North Central	167	0.5	0.1	-0.1	-0.1	0	-0.7	-0.2	0.5	0	2.9	0
West South Central	336	0.5	0.2	0.2	0.2	0.3	-0.6	-0.2	0	0	2.7	-0.1
Mountain	161	0.3	-0.1	0	-0.1	-0.1	-0.4	0	0.3	0	2.6	-0.2
Pacific	389	0.6	0.2	0.5	0.5	0.6	-0.3	0.1	0	0	3.3	0.4
Puerto Rico	50	1	0.8	-0.4	-0.4	0.4	-0.8	0	0	0	2.7	-0.1
Rural by Region:												
New England	24	0.3	-0.1	0.5	0.5	0.4	2.5	-0.1	0	0	3.3	0.4
Middle Atlantic	70	0	-0.3	0.4	0.4	0.1	1.3	-0.1	0	0	1.7	-1.2
South Atlantic	165	-0.1	-0.4	-0.4	-0.5	-0.9	2	-0.1	0	0.1	1.6	-1.2
East North Central	121	0.3	0	-0.1	-0.1	-0.1	1.1	-0.1	0	0.1	1.9	-0.9
East South Central	176	0.7	0.4	0.2	0.2	0.5	2.6	-0.2	0	0.1	3.4	0.5
West North Central	100	0.8	0.4	-0.1	-0.1	0.4	0.5	0	0.1	0	2.7	-0.2
West South Central	219	0.8	0.5	0.3	0.3	0.8	2.2	-0.1	0	0.1	3.7	0.8
Mountain	72	0.8	0.4	0	0	0.4	0.4	0	0.5	0	3.2	0.3
Pacific	31	0	-0.4	-0.1	-0.1	-0.5	1.2	-0.1	0	0	1.3	-1.6
By Payment Classification:												
Urban hospitals	2551	0.3	0	0	0	0	-0.2	0	0	0	2.4	-0.4
Large urban areas	1404	0.3	0	0	0	0	-0.3	0	0	0	2.4	-0.4
Other urban areas	1147	0.4	0	-0.1	-0.1	0	0	0.1	0.1	0	2.5	-0.4
Rural areas	921	0.4	0	0	0	0.1	1.5	-0.1	0	0.1	2.5	-0.4
Teaching Status:												

	No. of Hospitals[1]	FY 2011 Weights & MS-DRG Changes[2] (1)	Application of Recalibration Budget Neutrality[3] (2)	FY 2011 Wage Data[4] (3)	Application of Wage Budget Neutrality[5] (4)	Final FY 2011 MS-DRG, Relative Weights & Wage Index Changes, with Wage & Recalibration Budget Neutrality[6] (5)	FY 2011 MGCRB Reclassifications[7] (6)	Rural Floor Budget Neutrality and National Rural Floor Budget Neutrality[8] (7)	Application of the Frontier Wage Index[9] (8)	FY 2011 Out-Migration Adjustment[10] (9)	All FY 2011 Changes Prior to the CMI Adjustment (10)	All FY 2011 Changes w/CMI Adjustment[11] (11)
Nonteaching	2429	0.4	0.1	0.1	0.1	0.1	0.2	0	0	0	2.6	-0.3
Fewer than 100 residents	805	0.3	-0.1	0	0	-0.1	-0.1	0	0.1	0	2.4	-0.5
100 or more residents	238	0.3	0	-0.1	-0.1	-0.1	-0.2	0	0	0	2.4	-0.5
Urban DSH:												
Non-DSH	779	0.5	0.1	-0.1	-0.1	0	0	0.1	0	0.1	2.5	-0.4
100 or more beds	1531	0.3	0	0	0	0	-0.2	0	0	0	2.4	-0.4
Less than 100 beds	356	0.3	0	0.1	0.1	0.1	-0.1	0	0.1	0	2.4	-0.5
Rural DSH:			0	0	0	0.1	0.2	-0.1	0	0.1		
SCH	423	0.4	0	0	0.1	0	2.4	-0.1	0	0	2.2	-0.7
RRC	212	0.3	-0.1	-0.3	-0.3	-0.4	1	-0.2	0	0.3	2.7	-0.2
100 or more beds	30	0.2	0.3	0	0	0.2	1.2	-0.2	0	0.4	1.7	-1.2
Less than 100 beds	141	0.6	0	0	0	-0.1	-0.3	0	0.1	0	1.8	-1
Urban teaching and DSH:												
Both teaching and DSH	818	0.3	-0.1	-0.3	-0.3	-0.4	0.2	0.1	0	0.1	2.4	-0.5
Teaching and no DSH	161	0.3	0	0.2	0.1	0.2	0	0	0	0	2.1	-0.8
No teaching and DSH	1069	0.3	0.2	0.1	0	0.2	-0.3	0	0.1	0	2.5	-0.4
No teaching and no DSH	503	0.6	0.1	-0.1	-0.1	0.1	3.2	-0.1	0.1	0	2.8	-0.1
Special Hospital Types:												

	No. of Hospitals[1]	FY 2011 Weights & MS-DRG Changes[2] (1)	Application of Recalibration Budget Neutrality[3] (2)	FY 2011 Wage Data[4] (3)	Application of Wage Budget Neutrality[5] (4)	Final FY 2011 MS-DRG, Relative Weights & Wage Index Changes, with Wage & Recalibration Budget Neutrality[6] (5)	FY 2011 MGCRB Reclassifications[7] (6)	Rural Floor Budget Neutrality and National Rural Floor Budget Neutrality[8] (7)	Application of the Frontier Wage Index[9] (8)	FY 2011 Out-Migration Adjustment[10] (9)	All FY 2011 Changes Prior to the CMI Adjustment (10)	All FY 2011 Changes w/CMI Adjustment[11] (11)
RRC	180	0.4	0	0	0	0.1	0.1	0	0.1	0	2.5	-0.4
SCH	332	0.4	0	0	0	0	0.4	-0.1	0	0.2	2.3	-0.6
MDH	194	0.3	-0.2	0	0	-0.2	0.8	0	0	0	2.1	-0.8
SCH and RRC	117	0.2	0.3	0.1	0.1	0.3	0.4	0	0	0	3	0.1
MDH and RRC	13	0.6	0	0	0	-0.1	0	0	0.1	0	2.5	-0.3
Type of Ownership:												
Voluntary	1990	0.3	0.1	0.1	0.1	0.2	0	-0.1	0	0	2.4	-0.5
Proprietary	859	0.4	0	0	0	0.1	0	0	0	0	2.8	-0.1
Government	586	0.3	0	0	0	0	-0.4	-0.1	0	0	2.6	-0.3
Medicare Utilization as a Percent of Inpatient Days:												
0-25	353	0.3	0	0	0	0	-0.3	0	0.1	0	2.5	-0.3
25-50	1593	0.3	0	0	-0.1	-0.1	0.6	0	0	0	2.5	-0.4
50-65	1201	0.3	0.2	-0.2	-0.2	0.1	0.5	0.1	0	0	2.3	-0.6
Over 65	233	0.5	0	0	0	0	2	-0.1	0	0	2.5	-0.4
FY 2011 Reclassifications by the Medicare Geographic Classification Review Board:												
All Reclassified Hospitals	773	0.3	0	0	0	0	-0.7	0	0.1	0	2.4	-0.4

	No. of Hospitals[1]	FY 2011 Weights & MS-DRG Changes[2] (1)	Application of Recalibration Budget Neutrality[3] (2)	FY 2011 Wage Data[4] (3)	Application of Wage Budget Neutrality[5] (4)	Final FY 2011 MS-DRG, Relative Weights & Wage Index Changes, with Wage & Recalibration Budget Neutrality[6] (5)	FY 2011 MGCRB Reclassifications[7] (6)	Rural Floor Budget Neutrality and National Rural Floor Budget Neutrality[8] (7)	Application of the Frontier Wage Index[9] (8)	FY 2011 Out-Migration Adjustment[10] (9)	All FY 2011 Changes Prior to the CMI Adjustment (10)	All FY 2011 Changes w/CMI Adjustment[11] (11)
Non-Reclassified Hospitals	2699	0.3	0	0	0	0	1.8	-0.1	0	0	2.5	-0.4
Urban Hospitals Reclassified	442	0.3	0	0	0	0	-0.7	0	0.1	0	2.3	-0.5
Urban Nonreclassified Hospitals, FY 2011:	2022	0.3	0	0	0	0.1	2.7	-0.1	0	0	2.5	-0.4
All Rural Hospitals Reclassified FY 2011:	331	0.3	0.1	0	0	0.2	-0.2	-0.1	0	0.2	2.8	-0.1
Rural Nonreclassified Hospitals FY 2011:	585	0.5	-0.4	-0.1	-0.1	-0.5	-0.3	0.1	0	0	2.1	-0.7
All Section 401 Reclassified Hospitals:	37	0	-0.4	-0.1	-0.1	-0.5	3.2	-0.1	0	0.1	1.8	-1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	-0.1	-0.2	-0.4	-0.4	-0.6	0.8	0.3	0.3	0	1.9	-1
Specialty Hospitals												
Cardiac specialty Hospitals	19	-0.3	0.6	0.2	0.2	0.8	-0.8	-0.2	0.2	0	3.2	0.3

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 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 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 0.996731, in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the update to wage index data using FY 2007 cost report data.

[5] This column displays the payment impact of the application of the wage budget neutrality factor, which is calculated separately from the recalibration budget neutrality factor, and will be calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The wage budget neutrality factor is 1.000013.

[6] This column displays the combined payment impact of the changes in Columns 1 through 4 and the 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 0.996744 is the product of the wage budget neutrality factor and the recalibration budget neutrality factor.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 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 0.991264.

[8] This column displays the effects of the rural floor and the imputed floor, including the Affordable Care Act requirement that the floor budget neutrality is at a 100 percent national level adjustment. The rural and imputed floor budget neutrality factor is 0.996641.

[9] This column shows the impact of the new policy required under section 10324 of the Affordable Care Act that hospitals located in Frontier states have a wage index no less than 1.0 beginning in FY 2011.

[10] 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.

[11] This column shows the changes in payments from FY 2010 to FY 2011. It reflects the impact of the FY 2011 market basket update, and the reductions to the FY 2011 standardized amount due to the documentation and coding effect. The FY 2011 documentation and coding adjustment is -2.9 percent to the IPPS standardized amounts, -2.9 percent to the hospital-specific rates, and -2.6 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 changes displayed in Columns 5, 6, 7, and 8 (the changes displayed in Columns 2 and 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 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 final MS–DRG reclassifications, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in section II.E. of the preamble of this final rule, the 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 relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of this final rule. The changes to the relative weights and MS–DRGs shown in Column 2 are prior to any offset for budget neutrality. Overall, hospitals will experience a 0.3 percent increase and a 0.4 percent increase, respectively, 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.

The "All Hospitals" line in Column 1 indicates that changes due to MS–DRGs and relative weights will increase payments by 0.3 percent before application of the budget neutrality factor. The recalibration budget neutrality factor is 0.996731, 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 hospitals will not experience a change in payments, while rural hospitals will experience a 0.1 percent increase in payments when recalibration budget neutrality is applied.

E. Effects of Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for acute care hospitals for FY 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 New England region, which experiences a 0.5 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in the urban New England region (0.5 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 4.3 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 4.3 percent increase in average hourly wage. Of the 3,441 hospitals with wage data for both FYs 2010 and 2011, 1,621, or 47.1 percent, experienced an average hourly wage increase of 4.3 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, 38 will experience an increase of more than 5 percent and less than 10 percent and 8 will experience an increase of more than 10 percent. Among rural hospitals, 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, 939 rural hospitals will experience increases or decreases of less than 5 percent, while 2,424 urban hospitals will experience increases or decreases of less than 5 percent. Thirteen 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 illustrate a somewhat larger change in the wage index than will occur to the hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	8	0
Increase more than 5 percent and less than 10 percent	38	2
Increase or decrease less than 5 percent	2,424	939
Decrease more than 5 percent and less than 10 percent	13	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 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 revised wage budget neutrality factor is 1.000013, and the overall payment change is 0.0 percent.

G. Combined Effects of the MS–DRG and Wage Index Changes (Column 5)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or

adjustments to the wage index are to be budget neutral. We computed a wage budget neutrality factor of 1.000013, and a recalibration budget neutrality factor of 0.996731 (which is applied to the Puerto Rico-specific standardized amount and the hospital-specific rates). The product of the two budget neutrality factors is the cumulative wage and recalibration budget neutrality factor. The cumulative wage and recalibration budget neutrality adjustment is 0.996744, 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 rule, we are estimating that the 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.

We estimate that the combined impact of the changes to the relative weights and MS–DRGs and the 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 0.7 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 0.6 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, while the rural West South Central area would experience a 0.8 percent increase in payments.

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. Provisions in the Affordable Care Act required us to revert to FY 2008 average hourly wage reclassification criteria for reclassifications effective in FY 2011. Therefore, additional hospitals qualify for MGCRB reclassification.

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 0.991264 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral (section II.A. of the Addendum to this final rule). Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.7 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 0.4 percent increase in payments and rural hospitals in the New England region will experience a 2.5 percent increase in payments.

Table 9A of the Addendum to this final rule reflects the approved reclassifications for FY 2011.

I. Effects of the Rural Floor and Imputed Floor, Including Application of National Budget Neutrality (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 final rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 final rule, we finalized the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals received a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. 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, the Affordable Care Act requires that we apply one rural floor budget neutrality factor to the wage index, nationally. The FY 2011 rural floor budget neutrality factor applied to the wage index is 0.996641.

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. The Affordable Care Act requires that, effective for FY 2011, we apply rural floor and imputed floor budget neutrality at the national level, as we did in FY 2008.

Column 7 shows the projected impact of the rural floor and the imputed floor with the national rural and imputed floor budget neutrality factor applied to the wage index. The column compares the 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, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) experience a decrease in payments due to the budget neutrality adjustment applied nationally to their wage index.

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 do not benefit from the rural floor, but have their wage indexes downwardly adjusted to ensure that the application of the rural floor is budget neutral overall. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because those providers benefit from the rural floor. Urban hospitals in the New England region can expect 0.8 percent increase in payments because a large percentage of hospitals in this region receive the rural floor. Urban hospitals in the Middle Atlantic can expect a 0.2 percent increase in payments because New Jersey hospitals benefit from the imputed floor. Rural hospitals in most regions can expect a 0.1 to 0.2 percent decrease in payments because the rural and imputed floors only benefit urban hospitals.

J. Effects of the Application of the Frontier Wage Index (Column 8)

Section 10324(a) of Affordable Care Act requires that we establish a minimum post-reclassified wage-index of 1.00 for all hospitals located in "frontier States." "Frontier States" is defined in the statute as a State in which at least 50 percent of its counties have a population density lesser than 6 persons per square mile. Based on these criteria, five states (Montana, North Dakota, Nevada, South Dakota, and Wyoming) are considered frontier States and 51 hospitals located in those States will receive a frontier wage index of 1.0. This provision is not budget neutral and is estimated to increase IPPS operating payments by approximately $50 million.

Urban hospitals located in the West North Central region and urban hospitals located in the Mountain region will experience an increase in payments by 0.5 percent and 0.3 percent, respectively because many of the hospitals located in this region are frontier hospitals. Similarly, rural hospitals located in the Mountain region and rural hospitals in the West North Central region will

experience an increase in payments by 0.5 and 0.1, respectively.

K. Effects of the Wage Index Adjustment for Out-Migration (Column 9)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, small rural providers with less than 100 beds will experience a 0.4 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 $30 million.

L. Effects of All Changes Prior to Documentation and Coding (or 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 changes reflected in this final rule, other than the documentation and coding adjustment. Column 10 reflects the impact of all other FY 2011 changes relative to FY 2010, including those shown in Columns 1 through 9. We note that our baseline FY 2010 operating estimates account for the provisions under the Affordable Care Act that affected the FY 2010 operating payments. The average increase in payments under the IPPS for all hospitals is approximately 2.5 percent. This includes the 2.35 percent applicable percentage increase (including the −0.25 reduction to the market basket increase required under the Affordable Care Act). The application of −0.25 percentage point reduction to the FY 2010 required by the Affordable Care Act only affected payments for discharges on or after April 1, 2010, reducing payments by 0.1 percent in FY 2010. However, the 0.25 percentage point reduction for FY 2011 required under the Affordable Care Act was a cumulative reduction on the FY 2010 reduction, resulting in an additional 0.1 percent decrease in payments in FY 2011. In addition, it reflects the estimated 0.4 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), as described in the introduction to this Appendix and the Addendum to this final rule. It accounts for the non-budget neutral wage index provisions, including the frontier State wage index and the Section 505 out-commuting adjustment that increases payments by 0.1 percent. Finally, it accounts for −0.1 percent decrease in payments due to the expiration of section 508 reclassifications that had been extended for FY 2010 under the Affordable Care Act.

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.

M. Effects of All FY 2011 Changes With CMI Adjustment (Column 11)

Column 11 shows our estimate of the changes in payments per discharge from FY 2010 and FY 2011, resulting from all changes reflected in this final rule for FY 2011. The FY 2010 baseline estimates account for the provisions under the Affordable Care Act that affected the FY 2010 operating payments. Specifically, the FY 2010 baseline payment estimates account for the additional −0.25 reduction in the applicable percentage increase (hospitals are paid based on the updated FY 2010 rate for discharges occurring on or after April 1, 2010), and accounts for the extension of section 508 reclassifications for FY 2010. As discussed in section II.D. of the preamble of this final rule, this column includes the FY 2011 documentation and coding adjustment of −2.9 percent on the national standardized amount, −2.9 percent on the hospital-specific rates, and −2.6 percent on the Puerto Rico-specific standardized amount, which overall accounts for a 2.9 percent decrease in payments.

The average decrease in payments under the IPPS for all hospitals is approximately −0.4 percent. As described in Column 10, this average decrease includes the effects of the 2.35 percent applicable increase (including the 0.25 percentage point reduction) to the market basket update required under the Affordable Care Act), the 0.4 percentage point difference between the projected outlier payments in FY 2011 (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). In addition, it includes a −0.1 percent decrease in payments due to the expiration of section 508 reclassifications that had been extended for FY 2010 under the Affordable Care Act. Section 508 reclassification was not a budget-neutral provision. 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 11 may not equal the sum of the percentage changes described above.

The overall change in payments per discharge for hospitals paid under the IPPS in FY 2011 is estimated to decrease by 0.4 percent. The payment decreases among the hospital categories are largely attributed to the documentation and coding adjustments. Hospitals in urban areas would experience an estimated 0.4 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 0.4 percent in FY 2011 as compared to FY 2010.

Among urban census divisions, the largest estimated payment decreases will be 0.9 percent in the Middle Atlantic region because many of the urban providers in this region had benefited from section 508 reclassifications in FY 2010 that has expired for FY 2011. Urban hospitals in the Pacific will see the largest payment increases (0.4 percent) because urban providers in this region will experience increases in their wage index above the national average. Among the rural regions, the providers in the Middle Atlantic and South Atlantic region will experience the largest decrease in payments (1.2 percent) while rural hospitals in the Mountain region will experience an increase in payments by 0.3 percent because the rural providers in this region benefit from MGCRB reclassification and the frontier State wage index provision, implemented under the Affordable Care Act.

Among special categories of rural hospitals, MDHs will receive an estimated payment decrease 0.8 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 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 0.6 percent due to the 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 0.1 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 0.3 percent in FY 2011 relative to FY 2010 due to increases in payments attributable to changes in the MS–DRGs and relative weights.

N. Impact Analysis of Table II

Table II presents the projected impact of the 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 payments per discharge for FY 2011, as calculated under our models. The estimated FY 2010 payments per discharge incorporate the provisions in the Affordable Care Act. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The estimated percentage changes shown in the last column of Table II equal the estimated percentage changes in average payments per discharge from Column 11 of Table I.

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TABLE II.--IMPACT ANALYSIS OF 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 FY 2011 Payment Per Discharge (3)	All FY 2011 Changes (4)
All hospitals	3,472	$ 10,214	$ 10,171	-0.4
By Geographic Location:				
Urban hospitals	2,494	$ 10,650	$ 10,605	-0.4
Large urban areas (populations over 1 million)	1,362	$ 11,233	$ 11,184	-0.4
Other urban areas (populations of 1 million or fewer)	1,132	$ 9,939	$ 9,897	-0.4
Rural hospitals	978	$ 7,584	$ 7,556	-0.4
Bed Size (Urban):				
0-99 beds	622	$ 8,006	$ 7,981	-0.3
100-199 beds	785	$ 8,994	$ 8,947	-0.5
200-299 beds	460	$ 9,815	$ 9,773	-0.4
300-499 beds	430	$ 10,983	$ 10,939	-0.4
500 or more beds	197	$ 13,177	$ 13,123	-0.4
Bed Size (Rural):				
0-49 beds	348	$ 6,190	$ 6,187	-0.1
50-99 beds	368	$ 7,110	$ 7,062	-0.7
100-149 beds	156	$ 7,485	$ 7,462	-0.3
150-199 beds	60	$ 8,179	$ 8,159	-0.2
200 or more beds	46	$ 9,401	$ 9,380	-0.2
Urban by Region:				
New England	121	$ 11,102	$ 11,026	-0.7
Middle Atlantic	330	$ 11,763	$ 11,654	-0.9
South Atlantic	382	$ 9,856	$ 9,796	-0.6
East North Central	403	$ 10,038	$ 9,974	-0.6
East South Central	155	$ 9,568	$ 9,519	-0.5
West North Central	167	$ 10,195	$ 10,196	0
West South Central	336	$ 9,962	$ 9,947	-0.1
Mountain	161	$ 10,860	$ 10,834	-0.2
Pacific	389	$ 13,022	$ 13,073	0.4
Puerto Rico	50	$ 5,182	$ 5,178	-0.1
Rural by Region:				
New England	24	$ 10,035	$ 10,079	0.4
Middle Atlantic	70	$ 7,928	$ 7,834	-1.2
South Atlantic	165	$ 7,381	$ 7,291	-1.2
East North Central	121	$ 7,864	$ 7,789	-0.9
East South Central	176	$ 6,826	$ 6,863	0.5
West North Central	100	$ 8,028	$ 8,014	-0.2

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average FY 2011 Payment Per Discharge (3)	All FY 2011 Changes (4)
West South Central	219	$ 6,829	$ 6,881	0.8
Mountain	72	$ 8,251	$ 8,274	0.3
Pacific	31	$ 10,345	$ 10,182	-1.6
By Payment Classification:				
Urban hospitals	2,551	$ 10,627	$ 10,582	-0.4
Large urban areas (populations over 1 million)	1,404	$ 11,210	$ 11,162	-0.4
Other urban areas (populations of 1 million or fewer)	1,147	$ 9,911	$ 9,870	-0.4
Rural areas	921	$ 7,638	$ 7,609	-0.4
Teaching Status:				
Non-teaching	2,429	$ 8,561	$ 8,534	-0.3
Fewer than 100 Residents	805	$ 10,155	$ 10,104	-0.5
100 or more Residents	238	$ 15,146	$ 15,075	-0.5
Urban DSH:				
Non-DSH	779	$ 8,900	$ 8,866	-0.4
100 or more beds	1,531	$ 11,180	$ 11,133	-0.4
Less than 100 beds	356	$ 7,553	$ 7,518	-0.5
Rural DSH:				
SCH	423	$ 6,992	$ 6,945	-0.7
RRC	212	$ 8,440	$ 8,427	-0.2
100 or more beds	30	$ 6,550	$ 6,473	-1.2
Less than 100 beds	141	$ 5,936	$ 5,876	-1
Urban teaching and DSH:				
Both teaching and DSH	818	$ 12,225	$ 12,169	-0.5
Teaching and no DSH	161	$ 9,780	$ 9,701	-0.8
No teaching and DSH	1,069	$ 9,135	$ 9,102	-0.4
No teaching and no DSH	503	$ 8,488	$ 8,477	-0.1
Rural Hospital Types:				
RRC	180	$ 8,579	$ 8,545	-0.4
SCH	332	$ 7,896	$ 7,851	-0.6
MDH	194	$ 6,363	$ 6,313	-0.8
SCH and RRC	117	$ 9,458	$ 9,464	0.1
MDH and RRC	13	$ 8,275	$ 8,246	-0.3
Type of Ownership:				
Voluntary	1,990	$ 10,345	$ 10,292	-0.5
Proprietary	859	$ 9,107	$ 9,099	-0.1
Government	586	$ 10,852	$ 10,818	-0.3
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	$ 13,720	$ 13,675	-0.3
25-50	1,593	$ 11,133	$ 11,094	-0.4
50-65	1,201	$ 8,552	$ 8,501	-0.6

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average FY 2011 Payment Per Discharge (3)	All FY 2011 Changes (4)
Over 65	233	$ 7,446	$ 7,417	-0.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2011 Reclassifications:				
All Reclassified Hospitals FY 2011	773	$ 9,912	$ 9,870	-0.4
All Non-Reclassified Hospitals FY 2011	2,699	$ 10,319	$ 10,276	-0.4
Urban Reclassified Hospitals FY 2011:	442	$ 10,647	$ 10,590	-0.5
Urban Non-reclassified Hospitals FY 2011	2,022	$ 10,663	$ 10,621	-0.4
Rural Reclassified Hospitals FY 2011	331	$ 8,175	$ 8,169	-0.1
Rural Nonreclassified Hospitals FY 2011:	585	$ 6,837	$ 6,786	-0.7
All Section 401 Reclassified Hospitals:	37	$ 8,877	$ 8,784	-1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	$ 7,289	$ 7,218	-1
Specialty Hospitals				
Cardiac Hospitals	19	$ 11,476	$ 11,511	0.3

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VII. Effects of Other Policy Changes

In addition to those policy changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Effects of Proposed Policy on HACs, Including Infections

In section II.F. of the preamble of this final rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless, based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision results in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case. In addition, as discussed in section II.F.3.e. of the preamble of this final 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	$20
FY 2012	22
FY 2013	23
FY 2014	25
FY 2015	27

B. Effects of Policy Relating to New Medical Service and Technology Add-On Payments

In section II.I. of the preamble to this final 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. However, we are providing an estimate of additional payments for new technology add-on payments because such payments will have an impact on total operating IPPS payments in FY 2010.

We are continuing 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 Cardiowest™ Temporary Total Artificial Heart System (TAH-t) will increase overall FY 2011 payments by $9.54 million. For FY 2010, the applicant, Spiration, Inc., 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.

In addition to continuing 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, as discussed in section II.I. of the preamble to this final rule, we are approving the AutoLITT™ for new technology add-on payments for FY 2011. The applicant, Monteris Medical, estimates that approximately 170 Medicare beneficiaries would be eligible for the AutoLITT™. Therefore, based on the applicant's estimate and 50 percent of the estimated operating cost per case ($5,300), we currently estimate that payments for the AutoLITT™ will increase overall FY 2011 payments by $900,000.

C. Effects of 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 final rule, we are retiring one of the FY 2011 quality measures. We believe that this will 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 this final rule, we discuss our requirements for hospitals to report quality data in order to receive the full annual payment update for FY 2011, FY 2012, FY 2013, and FY 2014. We estimate that approximately 95 hospitals may not receive the full annual payment update in any fiscal year. Most of these hospitals are either small rural or small urban hospitals. However, at this time, information is not available to determine the number of hospitals that will not meet the requirements for the full payment update for FY 2011, FY 2012, FY 2013, and FY 2014.

For the FY 2012 payment determination, we did not adopt our proposal to require hospitals to submit all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures.

For the FY 2013 payment determination, we did not adopt our proposal that hospitals would 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 believe that the AMI-statin at discharge measure, which we adopted for FY 2013 payment determination, will 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 addition of four chart-abstracted measures and the one measure collected via NHSN that require hospitals to submit data on all inpatients is expected to create an additional burden for hospitals. The information needed for the 2 ED-Throughput measures is captured as routine documentation, and therefore is not expected to impose much additional burden. The 2 Global Immunization measures will 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 need to be collected will increase. However, this additional burden will be offset to some extent by our decision to retire two measures (PN–2 and PN–7). The information needed for the fifth measure, an SSI measure to be collected via NHSN, is structured to keep additional burden to a minimum, since hospitals in 21 States are already using NHSN and CDC supports more than 2000 hospitals that are already using NHSN.

We discussed the validation requirements for the FY 2011 annual payment update in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43883 through 43884). In the FY 2011 IPPS/LTCH PPS proposed rule, we noted that for 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 first quarter CY 2010 through third quarter CY 2010 (75 FR 23991 through 23993). 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 will 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 effective for the FY 2012 annual payment update, CMS will 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 twelve charts per hospital per quarter represents a minimal burden to the participating hospital.

We are adopting as final our proposal to modify our validation process for FY 2012. We believe that our FY 2012 policy, which will only validate data submitted by 800 hospitals for the FY 2012 RHQDAPU payment determination (as compared with our previous policy under which we validated data submitted by all hospitals participating in the RHQDAPU program), will not change the number of hospitals that fail the validation requirement for FY 2012 from previous years. We have changed the way we calculate the validation matches (that is, all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match), which will make it more difficult for hospitals to satisfy the validation requirement. However, we also are adopting as final our proposal to validate data for a smaller number of hospitals each year. In combination, we believe that these two proposed revisions will counterbalance each other and result in no additional impact to the number of hospitals failing our validation requirement for FY 2012. In addition, CMS conducted analysis in FY 2010 of past validation data which indicates that at least 95 percent of sampled hospitals are expected to pass the current 75 percent validation threshold starting in 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, the hospital must 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 20 hospitals would fail this requirement for FY 2012. We estimate that this requirement 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 component of the annual payment update at risk. This requirement is necessary so that CMS has all the information it needs to fairly and timely make a decision on the hospital's reconsideration request. We also anticipate that this requirement will benefit hospitals seeking reconsiderations because it will enable us to resolve potential issues earlier in the appeals process, obviating the need for a hearing before the Provider Reimbursement Review Board (PRRB). We believe that this benefit will greatly outweigh the burden of copying and mailing the requested records.

We note that beginning with FY 2014 and future years, we are considering adding two strata to the current RHQDAPU validation sample of SCIP, AMI, HF, and PN cases. We will consider selecting 2 additional samples of 3 cases per selected hospital per quarter to validate proposed surgical site infection, blood stream infection, ED-Throughput and global immunization measures, If proposed and adopted as final through a later rulemaking, CMS would randomly select a total of 18 records per quarter per validated hospital in six strata (SCIP, AMI, HF, PN, CDC/NHSN measures and ED-Throughput/ Global Immunization). The requirement of an

additional 6 charts per hospital submitted for validation will result in approximately 4800 additional 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 effective for the FY 2014 annual payment update, CMS will have expenditures of approximately $105,600 per quarter to collect the charts for the FY 2014 and future years annual payment update. Given that we reimburse for the data collection effort, we believe that a requirement of the additional records in FY 2014 per hospital per quarter represents a minimal burden to the participating hospital.

D. Effects of Policy on Payment for Transfer Cases From Medicare Participating Hospitals to Nonparticipating Hospitals and CAHs

In section IV.B. of the preamble of this final rule, we are expanding the acute care transfer policy to transfers to nonparticipating acute care hospitals and to CAHs. This 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 that any change in Medicare payments to hospitals associated with this change will 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 expansion of the acute care transfer policy will not have a material impact on Medicare payments to acute care hospitals.

E. Effects of the Low-Volume Hospital Payment Adjustment: Changes for FYs 2011 and 2012

As discussed in section IV.D. of the preamble to this final rule, the low-volume hospital payment adjustment changes for FYs 2011 and 2012 expand eligibility for the low-volume hospital payment adjustment to hospitals with less than 1,600 Medicare discharges (instead of the prior requirement of less than 800 total, Medicare and non-Medicare, discharges) and more than 15 miles from other IPPS hospitals (rather than the prior requirement of more than 25 miles). The payment adjustment is changed also from an empirically determined additional 25-percent payment adjustment to qualifying hospitals with less than 200 total discharges (69 FR 49099 through 49102 and 70 FR 47432 through 47434), to a continuous, linear sliding scale adjustment ranging from an additional 25 percent payment adjustment to qualifying hospitals with 200 or fewer Medicare discharges to no additional payment to hospitals with 1,600 or more Medicare discharges.

We estimate, based on FY 2009 claims data (March 2010 update of the MedPAR file), an additional 1,444 hospitals would meet the Medicare discharges criterion to qualify as a low-volume hospital. However, we are not able to estimate the number of these 1,444 hospitals that would also meet the distance criterion. The actual number of hospitals that would also meet the distance criterion to qualify as a low-volume hospital would be less, very likely much less, than the estimated 1,444 maximum number of potential low-volume hospitals for FY 2011. If all 1,444 hospitals that meet the Medicare discharge requirement also meet the distance requirement, an additional estimated $835 million would be required for FY 2011, based on each hospital's number of Medicare discharges and the corresponding payment adjustment amount. At this time, we are not able to estimate the impact of the change for FY 2012.

Our actuaries chose a 40-percent factor to estimate the percentage of hospitals that would meet the distance requirement, in addition to the discharge requirement, to be a low-volume hospital. For FY 2011, our actuaries estimate that there will be an additional cost of $380 million; for FY 2012, $450 million; and an additional $50 million being paid in FY 2013, for hospital stays at the end of FY 2012 that are paid at the beginning of FY 2013.

F. Effects of Change Relating to Payment Adjustment for Disproportionate Share Hospitals

In section IV.F. of the preamble of this final rule, we discuss the change, effective for FY 2011 and subsequent years, to 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 adopting a similar revised data matching process for calculating hospitals' DSH SSI fractions for FY 2011 and subsequent fiscal years. In addition, we will use, in the revised matching process, a later update of the MedPAR claims data file and the SSI eligibility data file. Specifically, we will 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 revision to the timing of the data match achieves 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 impact of the 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 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 will increase the number of inpatient claims for a given Federal fiscal year and, therefore, will 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 are for Medicare patients who are 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 are 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 will increase while it will 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 change to this policy, we are unable to determine if this issue has any cost or savings for FY 2011 and subsequent years.

Finally, our 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 are 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 will increase.

We did not receive any specific public comments on this impact section.

G. Effects of Change in Policy Relating to MDHs

1. Medicare Dependency: Counting Medicare Inpatients

In section IV.G.2. of the preamble of this final rule, we discuss our revision of the existing Medicare-dependency criterion for MDHs at § 412.108(a)(1)(iii) of the regulations which specify that "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 will include in the count of Medicare inpatient days or discharges, all days or discharges attributable to individuals entitled to Medicare Part A benefits, 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 this change to the MDH definition of Medicare dependency may allow 48 more IPPS hospitals to qualify as an MDH. We estimate that this change will result in increased expenditure of $3.6 million in FY 2011.

2. Extension of the MDH Program

In section IV.G.3. of the preamble to this final rule, we discuss section 3124 of the Affordable Care Act, which extended the MDH program for 1 additional year, from the end of FY 2011 (that is, for discharges before October 1, 2011) to the end of FY 2012 (that is, for discharges before October 1, 2012). The extension of the MDH program has no impact for FY 2011. For FY 2012, the extension allows the continuation of MDH status and the payment methodology for an MDH to be paid its hospital-specific rate, based on its FY 1982, 1987, or 2002 costs per discharge, rather than the Federal rate, if this results in a greater aggregate payment. Therefore, the impact of the MDH program extension is 1 additional year of updated hospital-specific rate payments for each MDH, if this results in a greater aggregate payment than Federal rate payments, rather than Federal rate payments for IPPS hospitals without special treatment as MDHs. Our actuaries estimate that this 1-year extension of the MDH program through FY 2012 will cost an additional $110 million.

H. Effects of 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 final rule, we discuss our clarification of 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 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 is not required for additional board certification in another subspecialty. We also are revising 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 clarification of existing policy and is not a policy revision or addition of a new policy. The 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 change to the regulations, will no longer be able to include such trainees in its FTE count for IME and direct GME purposes. 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 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 final rule, we discuss our finalized policy 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 changing our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. This policy change will 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 establishing an electronic submission process that will consist of either an e-mail mailbox or a Web site where hospitals will be able to submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement must be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are requring that the electronic affiliation agreement must be submitted either as a scanned copy, a Portable Document Format (PDF) version of that hard copy agreement, or in another electronic format that cannot be subject to manipulation. This requirement will 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 will 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 will minimize the paperwork burden for hospitals.

I. Effects of Changes Relating to CRNA Services Furnished in Rural Hospitals and CAHs

In section IV.I. of the preamble of this final rule, we discuss our amendment to 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 revising 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 revising the regulations to state that, effective for cost reporting periods beginning on or after October 1, 2010, hospitals and CAHs that have reclassified as rural pursuant to section

1886(d)(8)(E) of the Act and § 412.103 of the regulations are 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 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 will 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 will exceed this threshold. Therefore, while we believe the impact will be relatively minor, we are unable to quantify the impact of the change.

J. Effect of the Additional Payments to Qualifying Hospitals in Low Medicare Spending Counties

Under section 1109 of Public Law 111–152, Congress allocated $400 million to be spent for FYs 2011 and 2012 to qualifying hospitals located in the bottom quartile of counties with the lowest Medicare Part A and Part B spending per enrollee. In section IV.J. of the preamble to this final rule, we have identified the list of eligible counties and the qualifying hospitals located in those counties that will receive the $400 million. We are finalizing our proposal to spend $150 million in FY 2011 and $250 million in FY 2012. This money will be given to the qualifying hospitals by the fiscal intermediaries or MAC through a one-time annual payment. In section IV.J. of the preamble to this final rule, Table 1 lists the distribution of payments among the list of qualifying hospitals. In addition, Table 2 in section IV.J. of the preamble to this final rule lists the distribution of payment by State for FY 2011.

K. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.K of the preamble of this final rule, we discuss our implementation of section 410A of Public Law 108–173, which required the Secretary to establish a demonstration that would 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 V.K. of the preamble of this final 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 adjusting the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. 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.

In addition, an extension of this demonstration was mandated by the Affordable Care Act. The demonstration is extended for an additional 5 years and will be expanded to up to 30 hospitals. We are making an adjustment in this final rule of $70,483,384 to the national IPPS rates. This amount accounts for an estimate of the demonstration cost for FY 2011 for the 10 hospitals that are currently participating in the demonstration, and an estimate of the cost of the continuation of the 7 hospitals that have participated in the demonstration since its inception and that are still participating. This amount accounts for the portions of their cost reporting periods in FY 2010 that were not covered in the estimated cost of the demonstration in the FY 2010 IPPS final rule because we formulated these estimates under the assumption that the demonstration would end in FY 2010. The adjustment for this final rule also includes an estimate of the cost of participation in the demonstration for 20 additional hospitals in FY 2011. In addition, for this final rule, we had proposed in the May 4, 2010 proposed rule 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. However, this final rule does not contain this adjustment because the specific numeric value associated with this component of the adjustment to the national IPPS rates cannot be known because settled cost reports beginning in FY 2007 of the hospitals participating during FY 2007 in the demonstration are not available yet. We anticipate that those settled cost reports may be available prior to the publication of the FY 2012 IPPS proposed rule, at which time we would include a similar proposal.

L. 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 final rule, we discuss our amendment to the regulations to permit a CAH's election to be paid for outpatient services under the optional method to stay in effect until it is terminated. 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 amending 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 specifying that these CAHs will have until December 1, 2010, to terminate their election. We anticipate that there will be no additional Medicare expenditure associated with this change because we are not making any changes that govern payment rules for CAHs. Rather, we believe the regulatory changes will 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. Effects of the Payment for CAH Outpatient Services and Ambulance Services

In section VII.B.3. of the preamble of this final rule, we discuss our implementation of section 3128 of Public Law 111–148, which amends the regulations at § 413.70(b)(3)(ii)(A) to state that, effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient facility services under the optional method will be made at 101 percent of reasonable costs. We also are amending the regulations at § 413.70(b)(5)(i) to state that, effective for cost reporting periods beginning on or after January 1, 2004, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity. We do not believe these amendments will result in additional payments to CAHs for prior periods because we believe that, in fact, we have paid CAHs for these services at 101 percent of reasonable costs during these prior periods.

3. Consideration of Costs of Provider Taxes as Allowable Costs for CAHs

In section VI.B.4. of the preamble of this final rule, we discuss our clarification of our policy regarding the extent to which certain provider taxes may be considered allowable costs under Medicare, as described in sections 2212.1 and 2212.2 of the PRM–1. This is a clarification of our longstanding policy. Therefore, we have determined that there is no financial impact of the change.

M. Effects of Policy Relating to Effective Date of Provider Agreements and Supplier Approvals

In section VIII. of the preamble of this final rule, we discuss our clarification of 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, this clarification will not change the process for providers and suppliers. Therefore, we believe that the impact of our clarification is negligible.

N. Effects of Changes Relating to Hospital Rehabilitation Services and Respiratory Care Services Conditions of Participation

In section IX. of the preamble of this final rule, we discuss our 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 these changes will impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings due to the regulatory flexibility of these changes, which may allow for greater consistency with existing State laws and with hospital policies and procedures. The cost of implementing these changes will 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 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 will be offset by the benefits derived from the overall intent of these changes 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 changes will clarify existing hospital CoPs to make them more consistent not only with each other, but also with many State laws and with current practice. Therefore, no burden is being assessed as a result of the revisions of these CoPs, or on the communication of these revisions to staff that will be required by this final rule, as these practices are usual and customary business practices.

VIII. Effects of Changes in the Capital IPPS

A. General Considerations

Provisions of the Affordable Care Act necessitated revising the May 4, 2010 FY 2011 IPPS/LTCH PPS proposed rule. While the IPPS payment rates for capital-related costs were not directly affected by provisions of the Affordable Care Act, changes to the wage index as well as to the outlier payment adjustment factor were required by the law. Changes to the wage index affect the geographic adjustment factor (GAF) under the capital IPPS which is used in conjunction with a factor for changes in DRG classifications and weights to determine a budget neutrality adjustment factor in calculating the capital IPPS rate. A revision of the outlier payment adjustment factor was required because both inpatient operating and inpatient capital-related payments use a single set of thresholds to identify outlier cases. Changes resulting from the provisions of the Affordable Care Act are discussed in more detail in section II.A. of the preamble of the FY 2011 IPPS//LTCH PPS supplemental proposed rule published in the **Federal Register** on June 2, 2010.

For the impact analysis presented below, we used data from the March 2010 update of the FY 2009 MedPAR file and the March 2010 update of the Provider-Specific File (PSF) that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the March 2010 update of the most recently available hospital cost report data (FYs 2007 and 2008) 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 to this final rule, we made a −2.9 percent documentation and coding adjustment to the national capital 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 results in a cumulative adjustment factor of 0.9574 that we applied to the national capital rate to account for improvements in documentation and coding that do not reflect real changes in case mix under the MS–DRGs in FY 2011. We also adjusted the Puerto Rico-specific capital rate in FY 2011 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, it is possible that some individual hospitals are placed in the wrong category.

Using cases from the March 2010 update of the FY 2009 MedPAR file, we simulated payments under the capital IPPS for revised FY 2010 and revised FY 2011 (both years have been revised to account for provisions in the Affordable Care Act that required changes to the wage index and outlier threshold, as discussed above in this section) for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

The 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. 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 11.3 million in FY 2010 and 11.5 million in 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.A.1.a. of this final rule, the update is 1.5 percent for FY 2011.
- In addition to the FY 2011 update factor, the FY 2011 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 0.9990, an outlier adjustment factor of 0.9404, and a (special) exceptions adjustment factor of 0.9996.
- For FY 2011, as discussed above and in section V.E. of the preamble to this final rule, we applied a 0.9574 adjustment to the FY 2011 national capital rate for changes in documentation and coding that are expected to increase case-mix under the MS–DRGs but do not reflect real case-mix change.

B. Results

We used the actuarial model described above to estimate the potential impact of our 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 March 2010 update of the FY 2009 MedPAR file, the March 2010 update to the PSF, and the most recent cost report data from the March 2010 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2010, as revised per the Affordable Care Act, compared to FY 2011 based on the FY 2011 payment policies. Column 2 shows estimates of payments per case under our model for FY 2010 (as revised). Column 3 shows estimates of payments per case under our model for FY 2011. Column 4 shows the total percentage change in payments from revised FY 2010 to FY 2011. The change represented in Column 4 includes the 1.5 percent update to the capital Federal rate and other 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 capital rate for FY 2011 will increase 1.5 percent as compared to the FY 2010 capital rate. The changes to the GAFs are expected to result, on average, in a slight decrease in capital payments, although, for rural regions, it is more of a contributing factor to the overall decrease in capital payments than to urban areas, mostly due to the application of the rural floor to the wage index. We also are estimating an increase in outlier payments from FY 2010 to FY 2011 due primarily to an estimated decrease in capital IPPS payments per discharge. Since capital payments per discharge are projected to be slightly lower in FY 2011 compared to FY 2010, more cases would qualify for outlier payments. The net impact of these changes is an estimated −0.5 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, as well as hospitals in large urban areas, are expected to experience a 0.5 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 most other regions are estimated to experience slight decreases in capital payments from FY 2010 to FY 2011. For the urban regions, changes in capital payments range from a −1.0 percent in both the New England region and Middle Atlantic region to an increase of 0.2 percent for the Pacific region. The rural regions show estimates of a 1.7 percent change in capital payments from FY 2010 to FY 2011 in the Middle Atlantic region and Pacific region to a 1.9 percent increase for the Mountain region.

By type of ownership, proprietary and government hospitals are estimated to experience a 0.3 percent decrease in capital payments, while voluntary hospitals are estimated to experience a 0.6 percent decrease in capital payments per case from FY 2010 to FY 2011.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals 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, as revised per the Affordable Care Act. All reclassified and non-reclassified hospitals are expected to experience a decrease in capital payments in FY 2011 as compared to FY 2010. Urban reclassified and rural reclassified hospitals are expected to have a decrease in capital payments of 0.6 percent and 0.5 percent, respectively. For non-reclassified hospitals, the estimated decrease in capital payments is 0.4 percent for urban non-reclassified hospitals, and 0.9 percent for rural non-reclassified hospitals. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience a decrease of 1.2 percent in capital payments from FY 2010 to FY 2011.

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2010 Payments Compared To FY 2011 Payments]

	Number of hospitals	Average FY 2010 payments/ case	Average FY 2011 payments/ case	Change
By Geographic Location:				
All hospitals	3,472	795	791	-0.5
Large urban areas (populations over 1 million)	1,362	876	872	-0.5
Other urban areas (populations of 1 million of fewer)	1,132	785	781	-0.5
Rural areas	978	551	547	-0.7
Urban hospitals	2,494	835	831	-0.5
0-99 beds	622	653	650	-0.5
100-199 beds	785	719	714	-0.7
200-299 beds	460	781	776	-0.7
300-499 beds	430	855	851	-0.5
500 or more beds	197	1,009	1,007	-0.2
Rural hospitals	978	551	547	-0.7
0-49 beds	348	442	443	0.1
50-99 beds	368	516	511	-1.0
100-149 beds	156	553	549	-0.6
150-199 beds	60	598	597	-0.2
200 or more beds	46	671	664	-1.0
By Region:				
Urban by Region	2,494	835	831	-0.5
New England	121	867	858	-1.0
Middle Atlantic	330	891	881	-1.0
South Atlantic	382	786	781	-0.6
East North Central	403	810	805	-0.7
East South Central	155	745	740	-0.6
West North Central	167	823	824	0.1
West South Central	336	783	782	-0.1
Mountain	161	863	862	-0.1
Pacific	389	987	989	0.2
Puerto Rico	50	377	377	0.1
Rural by Region	978	551	547	-0.7
New England	24	729	733	0.5
Middle Atlantic	70	564	555	-1.7
South Atlantic	165	541	533	-1.5
East North Central	121	577	568	-1.4
East South Central	176	498	495	-0.6
West North Central	100	568	567	-0.2
West South Central	219	518	522	0.8
Mountain	72	554	564	1.9
Pacific	31	698	686	-1.7
By Payment Classification:				
All hospitals	3,472	795	791	-0.5
Large urban areas (populations over 1 million)	1,404	875	871	-0.5
Other urban areas (populations of 1 million of fewer)	1,147	784	780	-0.5
Rural areas	921	548	543	-0.7
Teaching Status:				
Non-teaching	2,429	677	673	-0.5
Fewer than 100 Residents	805	798	793	-0.7
100 or more Residents	238	1,129	1,126	-0.3
Urban DSH:				
100 or more beds	1,531	861	858	-0.4
Less than 100 beds	356	593	589	-0.7

	Number of hospitals	Average FY 2010 payments/ case	Average FY 2011 payments/ case	Change
Rural DSH:				
Sole Community (SCH/EACH)	423	480	478	-0.4
Referral Center (RRC/EACH)	212	605	600	-0.9
Other Rural:				
100 or more beds	30	498	490	-1.6
Less than 100 beds	141	456	449	-1.4
Urban teaching and DSH:				
Both teaching and DSH	818	933	929	-0.4
Teaching and no DSH	161	813	804	-1.1
No teaching and DSH	1,069	719	716	-0.5
No teaching and no DSH	503	740	738	-0.4
Rural Hospital Types:				
Non special status hospitals	2,432	838	834	-0.5
RRC/EACH	59	752	751	-0.1
SCH/EACH	34	689	702	1.9
Medicare-dependent hospitals (MDH)	10	469	462	-1.4
SCH, RRC and EACH	16	814	805	-1.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2011 Reclassifications:				
All Urban Reclassified	442	841	836	-0.6
All Urban Non-Reclassified	2,022	835	831	-0.4
All Rural Reclassified	331	594	591	-0.5
All Rural Non-Reclassified	585	493	488	-0.9
Other Reclassified Hospitals (Section 1886(d)(8)(B))	55	558	551	-1.2
Type of Ownership:				
Voluntary	1,990	809	804	-0.6
Proprietary	859	719	716	-0.3
Government	586	811	809	-0.3
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	970	969	-0.1
25-50	1,593	863	860	-0.4
50-65	1,201	682	676	-0.8
Over 65	233	584	579	-0.8

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IX. Effects of Payment Rate Changes and Policy Changes Under the LTCH PPS

A. Introduction and General Considerations

In section VII. of the preamble and section VII. of the Addendum to this final rule, we set forth the annual update to the payment rates for the LTCH PPS for FY 2011. In the preamble, we specify the statutory authority for the provisions that are presented, identify the policies and rationales for our decisions as well as alternatives that were considered. In this section IX. of Appendix A. to this final rule, we discuss the impact of the final changes to the payment rates, factors, and other payment rate policies related to the LTCH PPS that are presented in the preamble of this final rule in terms of their estimated fiscal impact on the Medicare budget and on LTCHs.

A number of the provisions of the Affordable Care Act affected the LTCH PPS. The provisions of the Affordable Care Act that affected LTCH payments for FY 2011 are reflected in this impact analysis.

Currently, our database of 423 LTCHs includes the data for 78 nonprofit (voluntary ownership control) LTCHs and 306 proprietary LTCHs. Of the remaining 39 LTCHs, 13 LTCHs are government-owned and operated and the ownership type of the other 26 LTCHs is unknown. In the impact analysis, we used the final rates, factors, and policies presented in this final rule, including the 0.50 percentage point reduction to the market basket update required by sections 1886(m)(3) and (m)(4) of the Act and the 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 $39,794.95, which reflects the 0.25 percentage point reduction applied to the RY 2010 market basket update required under sections 1886(m)(3) and (m)(4) of the Act (as established in the FY 2010 IPPS/LTCH PPS notice published in the **Federal Register** on June 2, 2010). Discharges in RY 2010 occurring on or after April 1, 2010 are paid under the revised RY 2010 standard Federal rate consistent with section 3401(p) of the Affordable Care Act. Discharges in RY 2010 occurring on or after October 1, 2009, and on or before March 31, 2010, are paid under the standard Federal rate of $39,896.65 (74 FR 44022). As discussed in section VII.A.2. of the Addendum to this final rule, consistent with our historical practice, we are finalizing an update to the standard Federal rate for FY 2011 by −0.49 percent and establishing a standard Federal rate of $39,599.95 for FY 2011. This includes a market basket update of 2.5 percent with a 0.50 percentage point reduction as required under sections 1886(m)(3) and (m)(4) of the Act, and the documentation and coding adjustment of −2.5 percent to account for increases in case-mix associated with the adoption of the MS–LTC–DRGs. Based on the best available data for the 423 LTCHs in our database, we estimate that the update to the standard Federal rate for FY 2011 (discussed in section VII.A.2. of the Addendum to this final rule) and the changes to the area wage adjustment for FY 2011 (discussed in section VII.B. of the Addendum to this final rule), in addition to an estimated increase in HCO payments and an estimated increase in SSO payments, would result in an increase in estimated payments from RY 2010 of approximately $22.3 million (or about 0.5 percent). Based on the 423 LTCHs in our database, we estimate FY 2011 LTCH PPS payments to be approximately $4.932 billion, an increase from RY 2010 LTCH PPS payments of approximately $4.909 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this final rule is considered a major economic rule, as defined in this section. We note the approximately $22.3 million 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 0.5 percent increase in estimated payments per discharge from RY 2010 to FY 2011 is attributable to several factors, including the −0.49 percent decrease to the standard Federal rate, changes in the

wage index values (including the change to the labor-related share) presented in section VII.B. of the Addendum to this final rule and projected increases in estimated HCO and SSO payments. As Table IV shows, the change attributable solely to the standard Federal rate is projected to result in an decrease of 0.4 percent in estimated payments per discharge from RY 2010 to FY 2011, on average, for all LTCHs, while the 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 VII.B. of this final rule, we are updating the wage index values for FY 2011 based on the most recent available data. In addition, we are finalizing a slight decrease in the labor-related share from 75.779 percent to 75.271 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. The wage data and the labor-related share are expected to increase LTCH PPS payments by 0.1 percent.

Table IV below shows the impact of the final payment rate and final policy changes on LTCH PPS payments for FY 2011 presented in this final rule 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 0.5 percent (shown in Column 8). This projected increase in payments is attributable to the impacts of the change to the standard Federal rate (−0.4 percent in Column 6) and the 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 (0.6 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 the total estimated LTCH PPS payments in FY 2011. An analysis of the most recent available LTCH PPS claims data (that is, FY 2009 claims data from the March 2010 update of the MedPAR file) indicates that the RY 2010 HCO threshold of $18,615 (as announced in the June 2, 2010 FY 2010 IPPS/LTCH PPS notice) 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 7.4 percent of the estimated total LTCH PPS payments in RY 2010. We note that the RY 2010 outlier payment estimate in this impact analysis takes into account for the revised RY 2010 rate and outlier threshold determined consistent with sections 1886(m)(3) and (4) of the Act and section 3401(p) of the Affordable Care Act that are used to make payments for discharges in RY 2010 that occur on or after April 1, 2010. We estimate that the impact of the increase in HCO payments would result in approximately a 0.6 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 the estimated total LTCH PPS payments, and estimated payments for HCO cases comprise approximately 8 percent of the estimated total LTCH PPS payments. Payments for HCO cases are based on 80 percent of the estimated cost of the case 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 final rule, based on the most recent available data, we believe that the provisions of this final rule relating to the LTCH PPS will result in an increase in estimated aggregate LTCH PPS payments and that the resulting LTCH PPS payment amounts result in appropriate Medicare payments.

B. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. As shown in Table IV, we are projecting a 0.9 percent increase in estimated payments per discharge for FY 2011 as compared to RY 2010 for rural LTCHs that will result from the changes presented in this final rule, as well as the effect of estimated changes to HCO and SSO payments. This estimated impact is based on the data for the 26 rural LTCHs in our database (out of 423 LTCHs), for which complete data were available. The RY 2010 average payment per case in Table IV accounts for the changes required by sections 1886(m)(3) and (4) of the Act and section 3401(p) of the Affordable Care Act, which affects payments for discharges occurring on or after April 1, 2010, as described below in section IX.C.3. of the Appendix to this final rule.

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 changes to the area wage adjustment and the reduction in the labor-related share from 75.779 to 75.271, which results in an estimated 0.6 percent increase in payments.

C. Anticipated Effects of LTCH PPS Payment Rate Change and Policy Changes

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, we project an increase in aggregate LTCH PPS payments in FY 2011 of approximately $22.3 million (or 0.5 percent) based on the 423 LTCHs in our database.

2. Impact of Moratorium and Other Provisions

Section 114(c) and (d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), as amended by section 4302 of the American Recovery and Reinvestment Act of 2009 (ARRA), provided for a 3-year delay in certain payment policies relating to LTCHs and LTCH satellite facilities. Sections 3106 and 10312 of the Affordable Care Act together provide for a 2-year extension of the 3-year delay in implementation of certain payment policies relating to certain LTCHs and LTCH satellite facilities. Specifically, these provisions affect payment adjustments for "very" short stay outliers (SSOs), the one-time adjustment to the standard Federal rate, the 25 percent payment threshold policy, and the moratorium on the establishment of new LTCHs and LTCH satellite facilities and the moratorium on the increase in LTCH beds in existing LTCHs or satellite facilities.

Sections 3106 and 10312 of the Affordable Care Act together provide for a 2-year extension of the 3-year delay in implementation of the revision to the SSO policy at § 412.529(c)(3)(i) that was finalized in the RY 2008 final rule. We estimate that the extension of the SSO provision will result in a projected increase in estimated aggregate LTCH PPS payments of approximately $20 million in FY 2011. Sections 3106 and 10312 of the Affordable Care Act together provide for a 2-year extension to several modifications to the regulations at § 412.534 and § 412.536 required by section 114(c) of MMSEA, as amended by section 4302 of the ARRA, which addressed the percentage thresholds between referring hospitals and LTCHs and satellites of LTCHs. We estimate that the implementation of this extension of the MMSEA provisions, as amended by the ARRA, pertaining to § 412.534 and § 412.536 will result in a projected increase in estimated aggregate LTCH PPS payments of approximately $20 million for FY 2011.

Regarding the 2-year extension of the moratorium on the development of new LTCHs and LTCH satellites and on the increase in beds in existing LTCHs and LTCH satellites, as we noted in the May 22, 2008 interim final rule with comment period when the original 3-year delay required by section 114(d) of the MMSEA, as amended by the ARRA, was implemented, we are unable to quantify the impact of the additional 2-year moratorium on the establishment of LTCHs, LTCH satellite facilities, and on the increase of LTCH beds in existing LTCHs or satellite facilities with limited exceptions. We are unable to provide an estimate of the impact of the 2-year extension of this provision because we have no way of determining how many LTCHs would have opened in the absence of the moratorium, nor do we have sufficient information at this time to determine how many new LTCHs will meet the criteria for an exception described in the statute.

3. 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 (the standard Federal rate multiplied by the MS–LTC–DRG relative weight), we make adjustments for differences in area wage levels, the 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 changes to the LTCH PPS payments presented in this final rule on different categories of LTCHs for FY 2011, it is necessary to estimate payments per discharge for RY 2010 using the rates, factors (including the FY 2010 GROUPER (Version 27.0), and relative weights and the policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030) and to include any changes to payments due to the provisions under sections 1886(m)(3) and (4) of the Act and section 3401(p) of the Affordable Care Act, which affects payments for discharges occurring on or after April 1, 2010 in RY 2010 (as announced in the June 2, 2010 FY 2010 IPPS/LTCH PPS notice). It is also necessary to estimate the payments per discharge that would be made under the final LTCH PPS rates, factors, policies, and GROUPER (Version 28.0) for FY 2011 (as discussed in III. of the preamble and section VII. of the Addendum to this final 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 2007 through FY 2008 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 423 LTCHs. We believe that the discharges based on the FY 2009 MedPAR data for the 423 LTCHs in our database, which includes 306 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.

4. 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 calculated a blended RY 2010 payment to account for changes in the rate in accordance with sections 1886(m)(3) and (m)(4) of the Act and section 3401(p) of the Affordable Care Act. Specifically, we applied the RY 2010 standard Federal rate (that is, $39,896.65, under which LTCH discharges occurring on or after October 1, 2009, and through March 31, 2010 are paid, and $39,794.95, under which LTCH discharges occurring on or after April 1, 2010 and through September 30, 2010 are paid). For modeling estimated LTCH PPS payments for FY 2011, we applied the FY 2011 standard Federal rate of $39,599.95, which will 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 the 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 current 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 finalized LTCH PPS FY 2011 labor-related share of 75.271 percent, the FY 2011 wage index values presented in Tables 12A and 12B of the Addendum to this final rule, and the FY 2011 COLA factors shown in the table in section VII.B.5. of the Addendum to the final rule.

As discussed above, our impact analysis reflects an estimated change in payments for SSO cases, as well as an estimated increase in payments for HCO cases (as described in section VII.C. of the Addendum to this final rule). In modeling payments for SSO and HCO cases in RY 2010, we applied an inflation factor of 1.025 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2009 MedPAR files and the best available CCRs from the March 2010 update of the PSF. In modeling payments for SSO and HCO cases in FY 2011, we applied an inflation factor of 1.050 (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 March 2010 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) for the first half of RY 2010, the revised RY 2010 HCO fixed-loss amount of $18,615 established in conjunction with implementing the provisions of sections 1886(m)(3) and (m)(4) of the Act and section 3401(p) of the Affordable Care Act for the second half of RY 2010, and the FY 2011 fixed loss amount of $18,785 (as discussed in section VII.C. of the Addendum to this final 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 payment rates and policy changes presented in this final rule. Table IV illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for 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 changes to the standard Federal rate (as discussed in section VII.A.2. of the Addendum to this final rule).
- The seventh column shows the percentage change in estimated payments per discharge from RY 2010 to FY 2011 for changes to the area wage adjustment at § 412.525(c) (as discussed in section VII.B. of the Addendum to the final 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 finalized and statutory changes (and includes the effect of estimated changes to HCO and SSO payments).

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TABLE IV: IMPACT OF FINAL PAYMENT RATE AND POLICY CHANGES TO LTCH PPS PAYMENTS FOR FY 2011 (ESTIMATED RY 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 Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Changes[5] (8)
ALL PROVIDERS	423	131,860	$37,235	$37,405	-0.4	0.1	0.5
BY LOCATION:							
RURAL	26	5,622	$31,668	$31,959	-0.5	0.6	0.9
URBAN	397	126,238	$37,483	$37,647	-0.4	0.1	0.4
LARGE	205	76,084	$38,981	$39,183	-0.4	0.1	0.5
OTHER	192	50,154	$35,212	$35,318	-0.4	0.1	0.3
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,275	$31,841	$32,045	-0.4	0.0	0.6
OCT. 1983 - SEPT. 1993	44	16,860	$38,351	$38,589	-0.4	0.1	0.6
OCT. 1993 - SEPT. 2002	189	64,142	$36,726	$36,852	-0.4	0.1	0.3
AFTER OCTOBER 2002	165	42,341	$38,324	$38,512	-0.4	0.2	0.5
UNKNOWN PARTICIPATION DATE	8	2,242	$37,963	$38,420	-0.5	0.5	1.2
BY OWNERSHIP TYPE:							
VOLUNTARY	78	20,057	$37,047	$37,352	-0.4	0.2	0.8
PROPRIETARY	306	107,239	$37,172	$37,307	-0.4	0.1	0.4
GOVERNMENT	13	1,775	$39,841	$40,240	-0.4	-0.1	1.0
UNKNOWN OWNERSHIP TYPE	26	2,789	$39,381	$39,730	-0.4	0.1	0.9
BY REGION:							
NEW ENGLAND	15	7,596	$32,618	$32,810	-0.4	-0.1	0.6
MIDDLE ATLANTIC	29	7,759	$38,107	$38,189	-0.4	-0.3	0.2
SOUTH ATLANTIC	55	14,715	$40,550	$40,654	-0.4	-0.2	0.3
EAST NORTH CENTRAL	69	19,285	$40,073	$40,277	-0.4	0.2	0.5
EAST SOUTH CENTRAL	31	7,945	$37,410	$37,507	-0.4	-0.1	0.3
WEST NORTH CENTRAL	24	5,201	$38,878	$38,976	-0.4	0.0	0.3
WEST SOUTH CENTRAL	143	50,617	$32,838	$32,999	-0.5	0.3	0.5

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 Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Changes[5] (8)
MOUNTAIN	32	6,289	$40,138	$40,322	-0.4	-0.1	0.5
PACIFIC	25	12,453	$46,806	$47,144	-0.4	0.5	0.7
BY BED SIZE:							
BEDS: 0-24	39	4,540	$32,946	$33,268	-0.5	0.6	1.0
BEDS: 25-49	196	42,047	$36,938	$37,016	-0.4	0.1	0.2
BEDS: 50-74	103	32,534	$38,200	$38,395	-0.4	0.1	0.5
BEDS: 75-124	50	22,870	$39,259	$39,563	-0.4	0.3	0.8
BEDS: 125-199	20	14,811	$35,227	$35,446	-0.4	0.2	0.6
BEDS: 200 +	15	15,058	$36,176	$36,248	-0.4	0.0	0.2

[1] Estimated RY 2010 payments based on a blend of the rates, factors and policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030), including the FY 2010 GROUPER (Version 27.0) and relative weights, and the RY 2010 rates and factors that reflect the provisions of sections 1886(m)(3) and (m)(4) of the Act and section 3401(p) of the Affordable Care Act as discussed in the June 2, 2010 FY 2010 IPPS/LTCH PPS notice.

[2] Estimated FY 2011 LTCH PPS payments based on the payment rates and policy changes presented in the preamble and the Addendum to this final rule.

[3] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for the final changes to the standard Federal rate, as discussed in section VII.A.2. of the Addendum to this final rule.

[4] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for changes to the area wage adjustment at §412.525(c) (as discussed in section VII.B. of the Addendum to the final 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 final changes presented in the preamble of this final rule. Note this column, which shows the percent change in estimated payments per discharge for all changes, does not equal the sum of the percent changes in estimated payments per discharge for changes to the standard Federal rate (column 6) and the changes to the area wage adjustment (Column 7) due to the effect of estimated changes in both 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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5. Results

Based on the most recent available data for 423 LTCHs, we have prepared the following summary of the impact (as shown in Table IV) of the LTCH PPS payment rate and policy changes presented in this final rule. The impact analysis in Table IV shows that estimated payments per discharge are expected to increase approximately 0.5 percent, on average, for all LTCHs from RY 2010 to FY 2011 as a result of the finalized payment rate and policy changes presented in this final rule, as well as estimated increases in HCO and SSO payments. We note that we applied a −0.49 percent update to the standard Federal rate for FY 2011, based on the latest market basket estimate (2.5 percent), the −0.50 percentage point reduction required under sections 1886(m)(3) and (m)(4) of the Act, and the adjustment for the effect of changes in documentation and coding in FY 2008 and FY 2009 of −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 decrease of approximately −0.5 percent to the standard Federal rate is projected to result in approximately a −0.4 percent change in estimated payments per discharge for all LTCHs from RY 2010 to FY 2011. Because payments to cost-based SSO cases and a portion of payments to SSO cases that are paid based on the "blend" option of the SSO payment formula at § 412.529(c)(2)(iv) are not affected by the update to the standard Federal rate, we estimate that the effect of the 0.49 percent reduction to the standard Federal rate would result in a 0.4 percent reduction on estimated aggregate LTCH PPS payments to *all* LTCH PPS cases, including SSO cases. 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 0.5 percent (as shown in Table IV) was determined by comparing estimated FY 2011 LTCH PPS payments (using the final rates, final policies and statutory changes discussed in this final rule) to estimated RY 2010 LTCH PPS payments (as described above in section IX.C.3. of this Appendix).

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 0.5 percent for all changes. For rural LTCHs, the percent change for all changes is estimated to be 0.9 percent, while for urban LTCHs, we estimate the increase to be 0.4 percent. Large urban LTCHs are projected to experience an increase of 0.5 percent in payments per discharge from RY 2010 to FY 2011, while other urban LTCHs are projected to experience an increase of 0.3 percent in 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 in the Medicare program between October 1993 and September 2002. These hospitals are projected to experience nearly the average increase (0.3 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 the Medicare program before October 1983, LTCHs are projected to experience a higher than average percent increase (0.6 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 slightly higher than average increase in estimated payments because of increases in their wage data, increase under the MS–LTC–DRG GROUPER (Version 28) and relative weights, and 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 also projected to experience a slightly higher than average increase (0.6 percent) in estimated payments from RY 2010 to FY 2011. LTCHs that began participating in Medicare after October 2002 currently represent approximately 39 percent of all LTCHs, and are projected to experience an average increase (0.5 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 (0.8 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 (72 percent) of LTCHs are identified as proprietary and these LTCHs are projected to experience an average increase (0.4 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 (1.0 percent) in estimated payments primarily due to a larger than the average increase in estimated HCO payments and increases under the 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 Pacific region (0.7 percent, as shown in Table IV). The estimated percent increase in payments per discharge from RY 2010 to FY 2011 for the Pacific is largely attributable to the projected increase in estimated HCO and SSO payments and changes in their wage adjustment.

In contrast, LTCHs located in the Middle Atlantic region are projected to experience the smallest increase in estimated payments per discharge from RY 2010 to FY 2011. The average estimated increase in payments of 0.2 percent for LTCHs in the Middle Atlantic region is primarily due to estimated decreases in payments associated with the wage index because 50 percent of LTCHs located in this region will have a FY 2011 wage index value that is less than their RY 2010 wage index value.

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) would experience a 1.0 percent increase in payments due to increases in their wage index while large LTCHs (200+ beds) would experience a 0.2 percent increase in payments. 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 (0.8 percent and 0.6 percent, respectively) primarily due to a larger than average estimated increase in payments from the FY 2011 changes to the area wage adjustment.

D. Effect on the Medicare Program

As noted previously, we project that the provisions of this final rule would result in an increase in estimated aggregate LTCH PPS payments in FY 2011 of approximately $22.3 million (or about 0.5 percent) for the 423 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 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 final rule, we discuss the removal of the Medicaid requirement for Joint Commission accreditation of psychiatric hospitals and hospitals with inpatient psychiatric programs. Psychiatric hospitals will have the choice of undergoing a State survey to determine whether the hospital meets 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. Likewise, hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey to determine whether the hospital meets 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.

Ensuring access to services is a priority for CMS, and we believe that this revision to the regulations will result in an increased number of psychiatric hospitals and hospitals with inpatient psychiatric programs being able to provide services. In addition, the 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 policy under the RFA because we have determined that the policy will 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 policy will 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 policy will 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 policy does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

XI. Alternatives Considered

This final rule contains a range of policies. The preamble of this final rule provides descriptions of the statutory provisions that are addressed, identifies policies 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 final MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall decrease of 0.4 percent

in operating payments. We estimate that operating payments will decrease by approximately $440 million in FY 2011. In addition, we estimates the reporting of hospital quality data program costs at $2.4 million, a savings of $20 million associated with the HACs policies, an additional spending of $18.2 million for new technology add-on payments, an additional $150 million to hospitals that qualify for an additional payment as provided under section 1109 of Public Law 111–152, and all other operating payment policies described in section VII. of this Appendix. These estimates, added to our FY 2011 operating estimate of −$440 million, result in a decrease of $290 million for FY 2011. We estimate that capital payments will experience −0.5 percent change in payments per case, as shown in Table III of section VIII. of this Appendix. We project that there will be a $21 million decrease in capital payments in FY 2011 compared to FY 2010. The cumulative operating and capital payments should result in a net decrease of $311 million to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this final rule constitute a regulatory impact analysis.

B. LTCHs

Overall, LTCHs are projected to experience an increase in estimated payments per discharge in FY 2011. In the impact analysis, we are using the final rates, factors, and policies presented in this final rule, including final 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 423 LTCHs in our database, we estimate that FY 2011 LTCH PPS payments will increase approximately $22 million (or about 0.5 percent).

XIII. Accounting Statements

A. Acute Care Hospitals

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table V below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the finalized changes to the IPPS presented in this final rule. All expenditures are classified as transfers to Medicare providers.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2010 TO FY 2011

Category	Transfers
Annualized Monetized Transfers.	−$311 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	−$311 million.

B. LTCHs

As discussed in section IX. of this Appendix, the impact analysis for the finalized changes under the LTCH PPS for this final rule projects an increase in estimated aggregate payments of approximately $22 million (or about 0.5 percent) for the 423 LTCHs in our database that are subject to payment under the LTCH PPS. Therefore, as required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table VI below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule as they relate to changes to the LTCH PPS. Table VI provides our best estimate of the estimated increase in Medicare payments under the LTCH PPS as a result of the finalized provisions presented in this final rule based on the data for the 423 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: $22 million.
From Whom to Whom	Federal Government to LTCH PPS Medicare Providers.
Total	$22 million.

XIV. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Executive Office of Management and Budget reviewed this final rule.

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for certain hospitals excluded from the IPPS, as well as LTCHs, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2011

Several provisions of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152, collectively) affected the hospital inpatient update for both FYs 2010 and 2011. However, due to the timing of the passage of the legislation, we were unable to address those provisions in the FY 2011 IPPS/LTCH PPS proposed rule issued in the **Federal Register** on May 4, 2010 (75 FR 30756). On June 2, 2010, we issued a supplemental proposed rule (75 FR 30918) to the FY 2011 IPPS/LTCH PPS proposed rule to address these provisions. The discussion below reflects both the provisions of the initial FY 2011 proposed rule and the supplemental proposed rule relative to the FY 2011 hospital inpatient update and any public comments that we received on both documents. We note that, in the June 2, 2010 supplemental proposed rule, we did not propose to address the provisions of section 3401 of the Affordable Care Act, which provided for a productivity adjustment for FY 2012 and subsequent fiscal years. Rather, we indicated that the provisions of section 3401 that affect FY 2012 would be addressed in future rulemaking.

A. FY 2011 Inpatient Hospital Update

Section 3401(a) of the Affordable Care Act amended section 1886(b)(3)(B)(i) of the Act to provide that the FY 2011 applicable percentage increase for IPPS hospitals equals the rate-of-increase in the hospital market basket for IPPS hospitals in all areas is reduced by 0.25 percentage point, subject to the hospital submitting quality data under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide quality data, the update is equal to the market basket percentage increase minus a 0.25 percentage point less an additional 2.0 percentage points. Section 3401(a)(4) of the Affordable Care Act further states that this amendment may result in the applicable percentage increase being less than zero.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24321 and 24322), we announced that, due to the timing of the passage of the Affordable Care Act, we were unable to address those statutory provisions in that proposed rule. In that proposed rule, 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 estimated that the FY 2011 update to the operating standardized

amount would be 2.4 percent (that is, the then 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 estimated that the update to the operating standardized amount would be 0.4 percent (that is, the then current estimate of the market basket rate-of-increase minus 2.0 percentage points).

In the FY 2011 IPPS/LTCH PPS supplemental proposed rule (75 FR 30921 through 30923), we stated that, consistent with the amendments to section 1886(b)(3)(B)(i) of the Act made by section 3401 of the Affordable Care Act, for FY 2011, we are required to reduce the hospital market basket update by 0.25 percentage points. Therefore, based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2011 market basket increase, the estimated update to the FY 2011 operating standardized amount was 2.15 percent (that is, the FY 2011 estimate of the market basket rate-of-increase of 2.4 percent minus 0.25 percentage points) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the estimated update to the operating standardized amount was 0.15 percent (that is, the adjusted FY 2011 estimate of the market basket rate-of-increase of 2.15 percent minus 2.0 percentage points).

Since publication of the FY 2011 IPPS/LTCH PPS supplemental proposed rule, our estimate of the market basket for FY 2011 has changed. Therefore, we are adopting in this final rule, based on IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2011 market basket increase, with historical data through the 2010 first quarter, an applicable percentage increase for FY 2011 of 2.35 percent (that is, the current FY 2011 estimate of the market basket rate-of-increase of 2.6 percent minus 0.25 percentage point) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the update to the operating standardized amount is 0.35 percent (that is, the FY 2011 applicable percentage increase of 2.35 percent minus 2.0 percentage points). As discussed in section IV.N. of the preamble to this final rule, we are adopting as final, without modification, our proposed changes to § 412.64(d) to reflect current law.

B. Update for SCHs and MDHs for FY 2011

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase applicable to the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase 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). Because the Act sets the update factor for SCHs and MDHs equal to the update factor for all other IPPS hospitals, the update to the hospital specific rates for SCHs and MDHs is also subject to the amendments to section 1886(b)(3)(B)(i) of the Act made by section 3401(a) of the Affordable Care Act. Because the Act requires us to apply to the hospital-specific rates the update factor for all other IPPS hospitals, the update to the hospital specific rates for FY 2011 for SCHs and MDHs is also subject to section 1886(b)(3)(B)(i) of the Act, as amended by the Affordable Care Act. Accordingly, the FY 2011 update to the hospital-specific rates applicable to SCHs and MDHs is 2.35 percent for hospitals that submit quality data or 0.35 percent for hospitals that fail to submit quality data. As discussed in section IV.N. of the preamble to this final rule, we are adopting as final our proposed changes to the regulations at §§ 412.73(c)(15), 412.75(d), 412.77(e), 412.78(e), and 412.79(d) to implement the statutory reduction to the FY 2011 market basket.

C. FY 2011 Puerto Rico Hospital Update

Section 1886(d)(9)(C)(i) of the Act is the basis for determining the applicable percentage increase applied to the Puerto Rico-specific standardized amount. Section 1886(d)(9)(C)(i) of the Act provides that the Puerto Rico standardized amount shall be adjusted in accordance with the final determination of the Secretary under section 1886(d)(4) of the Act. Section 1886(e)(4)(1) of the Act in turn directs the Secretary to recommend an appropriate change factor for Puerto Rico hospitals taking into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, as well as the recommendations of MedPAC. In order to maintain consistency between the portion of the rates paid to Puerto Rico hospitals under the IPPS based on the national standardized amount and the portion based on the Puerto Rico-specific standardized rate, beginning in FY 2004, we have set the update to the Puerto Rico-specific operating standardized amount equal to the update to the national operating standardized amount for all IPPS hospitals.

As discussed in the preamble to this final rule, the amendments to section 1886(b)(3)(B)(i) of the Act by sections 3401(a) and 10319(a) of the Affordable Care Act affected only the update factor applicable to the national standardized rate for IPPS hospitals and the hospital-specific rates; they do not mandate any revisions to the update factor applicable to the Puerto Rico-specific standardized amount. Rather, as noted above, sections 1886(d)(9)(C)(i) and (e)(4) of the Act direct us to adopt an appropriate change factor for the FY 2010 Puerto Rico-specific standardized amount, which we did in the FY 2010 IPPS/LTCH PPS final rule after notice and consideration of public comments. Therefore, we do not believe we have the authority to adjust the FY 2010 update factor for the Puerto Rico-specific operating standardized amount for the second half of FY 2010 equal to the update factor applicable to the national standardized amount or the hospital-specific rates (that is the market basket minus 0.25 percentage points). Accordingly, the FY 2010 update to the Puerto Rico-specific operating standardized amount is 2.1 percent (that is, the FY 2010 estimate of the market basket rate-of-increase) for the entire FY 2010.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24321), for FY 2011, consistent with our past practice, we proposed to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. In the June 2, 2010 supplemental proposed rule (75 FR 30923), consistent with our past practice of applying the same update factor to the Puerto Rico-specific standardized amount as applied to the national standardized amount (and to conform to the changes to calculation of the national standardized amount made by the Affordable Care Act), for FY 2011, we proposed to revise the regulations at § 412.211(c) to set the update factor for the Puerto Rico-specific operating standardized amount equal to the update factor applied to the national standardized amount for all IPPS hospitals. We did not receive any public comments on our proposal. Therefore, in the preamble of this final rule, we adopted as final, without modification, the proposed changes to revise § 412.211(c). Consequently, we are applying an update factor for the Puerto Rico-specific standardized amount equal to the FY 2011 IPPS applicable percentage increase (the market basket rate-of-increase of 2.6 percent minus 0.25 percentage point, or 2.35 percent), for FY 2011.

D. Update for Hospitals Excluded From the IPPS

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. As we proposed, we are providing our current estimate of the FY 2011 IPPS operating market basket percentage increase (2.6 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 final rule, we are establishing an update to the LTCH PPS standard Federal rate for FY 2011 based on the full LTCH PPS market basket increase estimate (2.5 percent), including the requirement that we reduce the LTCH PPS market basket increase by 0.50 percentage point reduction in accordance with sections 3401(c), 10319(b) and 1105(b) of the Affordable Care Act which amended section 1886(m) of the Act, of 2.0 percent and an adjustment to account for the increase in case-mix in prior periods (FYs 2008 and

2009) that resulted from changes in documentation and coding practices of −2.5 percent. Accordingly, the update factor to the standard Federal rate for FY 2011 is −0.49 percent (that is, we are applying a factor of 0.9951 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.020 × 1 divided by 1.025 = 0.9951 or −0.49 percent).

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. Section 1886(s)(3)(A) of the Act, which was added by section 3401(f) of the Affordable Care Act, as further amended by section 10319(e) and by section 1105 of such Act, requires the application of an "Other Adjustment" that reduces any update to the IPF PPS base rate by 0.25 percentage point for the rate year beginning in 2010. Therefore, as announced in the IPF RY 2011 notice (75 FR 23109), we reduced the update to the IPF PPS base rate of 2.4 percent (based on the FY 2002-based RPL market basket and IHS Global Insight, Inc.'s first quarter 2010 forecast) by 0.25 percentage point for RY 2011.

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). Section 1886(j)(3)(D) of the Act, which was added by Section 3401(d) of the Affordable Care Act, as further amended by section 10319 and by section 1105 of such Act, requires the Secretary to reduce the market basket factor by 0.25 percentage point for FY 2011. Therefore, as announced in the IRF FY 2011 notice (75 FR 42848 and 42849), we reduced the update to the IRF PPS Federal rate of 2.5 percent (based on the FY 2002-based RPL market basket and IHS Global Insight, Inc.'s second quarter 2010 forecast) by 0.25 percentage point for FY 2011. Thus, the adjusted RPL market basket increase factor is 2.25 percent for FY 2011.

III. Secretary's Final 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 (and prior to other adjustments required under the statute), 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. As discussed above, we finalized our proposal to revise § 412.211(c) to set the update factor for the Puerto Rico-specific operating standardized amount equal to the update factor applied to the national standardized amount for all IPPS hospitals. Therefore, we are applying an update factor for the Puerto Rico-specific standardized amount equal to the FY 2011 IPPS applicable percentage increase (the market basket rate-of-increase of 2.6 percent minus 0.25 percentage points), or 2.35 percent, for FY 2011.

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 policy set forth in section VII. of the preamble of this final rule, we are recommending an update of −0.49 percent to the LTCH PPS standard Federal rate. In addition, consistent with the update specified in the FY 2011 IRF PPS notice (as described above), we are recommending an update of 2.25 percent to the IRF PPS Federal rate for FY 2011. Finally, consistent with the update specified in the FY 2011 IPF PPS notice (as described above), we are recommending an update of 2.4 percent reduced by 0.25 percentage point 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 final rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The update to the capital rate is discussed in section III. of the Addendum to this final rule.

We did not receive any public comments on MedPAC's recommendation.

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