Federal Register

Wednesday,
May 25, 2005

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1290–P]

RIN 0938–AN43

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities for Federal fiscal year 2006 as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before August 1 before each fiscal year, the classification and weighting factors for the inpatient rehabilitation facilities case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

In addition, we are proposing new policies and are proposing to change existing policies regarding the prospective payment system within the authority granted under section 1886(j) of the Act.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 18, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1290–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By 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–1290–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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

3. *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 one of the following addresses. 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. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(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.)

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: Pete Diaz, (410) 786–1235. Susanne Seagrave, (410) 786–0044. Mollie Knight, (410) 786–7984 for information regarding the market basket and labor-related share. August Nemec, (410) 786–0612 for information regarding the tier comorbidities. Zinnia Ng, (410) 786–4587 for information regarding the wage index and Core-Based Statistical Areas (CBSAs).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1290–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

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. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

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

ADC—Average Daily Census
AHA—American Hospital Association
AMI—Acute Myocardial Infarction
BBA—Balanced Budget Act of 1997 (BBA), Pub. L. 105–33
BBRA—Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA—Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BLS—Bureau of Labor Statistics
CART—Classification and Regression Trees
CBSA—Core-Based Statistical Areas
CCR—Cost-to-charge ratio
CMGs—Case-Mix Groups
CMI—Case Mix Index
CMSA—Consolidated Metropolitan Statistical Area
CPI—Consumer Price Index
DSH—Disproportionate Share Hospital
ECI—Employment Cost Index
FI—Fiscal Intermediary
FIM—Functional Independence Measure
FIM–FRGs—Functional Independence Measures—Function Related Groups
FRG—Function Related Group
FTE—Full-time equivalent
FY—Federal Fiscal Year
GME—Graduate Medical Education
HCRIS—Healthcare Cost Report Information System
HIPAA—Health Insurance Portability and Accountability Act
HHA—Home Health Agency
IME—Indirect Medical Education
IFMC—Iowa Foundation for Medical Care
IPF—Inpatient Psychiatric Facility
IPPS—Inpatient Prospective Payment System
IRF—Inpatient Rehabilitation Facility
IRF–PAI—Inpatient Rehabilitation Facility—Patient Assessment Instrument
IRF–PPS—Inpatient Rehabilitation Facility—Prospective Payment System
IRVEN—Inpatient Rehabilitation Validation and Entry
LIP—Low-income percentage
MEDPAR—Medicare Provider Analysis and Review
MSA—Metropolitan Statistical Area
NECMA—New England County Metropolitan Area
NOS—Not Otherwise Specified
NTIS—National Technical Information Service
OMB—Office of Management and Budget
OSCAR—Online Survey, Certification, and Reporting
PAI—Patient Assessment Instrument
PLI—Professional Liability Insurance
PMSA—Primary Metropolitan Statistical Area
PPI—Producer Price Index
PPS—Prospective Payment System
RIC—Rehabilitation Impairment Category
RPL—Rehabilitation Hospital, Psychiatric Hospital, and Long-Term Care Hospital Market Basket
TEFRA—Tax Equity and Fiscal Responsibility Act
TEP—Technical Expert Panel

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

A. General Overview of the Current Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 4421 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), provides for the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Social Security Act (the Act), for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs).

Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the August 7, 2001 final rule, we are providing below a general description of the IRF PPS.

The IRF PPS, as described in the August 7, 2001 final rule, uses Federal prospective payment rates across 100 distinct case-mix groups (CMGs). Ninety-five CMGs were constructed using rehabilitation impairment categories, functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). Five special CMGs were constructed to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors account for the relative difference in resource use across all CMGs. Within each CMG, the weighting factors were ''tiered'' based on the estimated effects that certain comorbidities have on resource use.

The Federal PPS rates were established using a standardized payment amount (previously referred to as the budget-neutral conversion factor). The standardized payment amount was previously called the budget neutral conversion factor because it reflected a budget neutrality adjustment for FYs 2001 and 2002, as described in § 412.624(d)(2). However, the statute requires a budget neutrality adjustment only for FYs 2001 and 2002. Accordingly, for subsequent years we believe it is more consistent with the statute to refer to the standardized payment as the standardized payment conversion factor, rather than refer to it as a budget neutral conversion factor (see 68 FR 45674, 45684 and 45685). Therefore, we will refer to the standardized payment amount in this proposed rule as the standard payment conversion factor.

For each of the tiers within a CMG, the relative weighting factors were

applied to the standard payment conversion factor to compute the unadjusted Federal prospective payment rates. Under the current system, adjustments that accounted for geographic variations in wages (wage index), the percentage of low-income patients, and location in a rural area were applied to the IRF's unadjusted Federal prospective payment rates. In addition, adjustments were made to account for the early transfer of a patient, interrupted stays, and high cost outliers.

Lastly, the IRF's final prospective payment amount was determined under the transition methodology prescribed in section 1886(j) of the Act. Specifically, for cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, section 1886(j)(1) of the Act and as specified in § 412.626 provides that IRFs transitioning into the PPS would receive a ''blended payment.'' For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, these blended payments consisted of 66⅔ percent of the Federal IRF PPS rate and 33⅓ percent of the payment that the IRF would have been paid had the IRF PPS not been implemented. However, during the transition period, an IRF with a cost reporting period beginning on or after January 1, 2002 and before October 1, 2002 could have elected to bypass this blended payment and be paid 100 percent of the Federal IRF PPS rate. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), the transition methodology expired, and payments for all IRFs consist of 100 percent of the Federal IRF PPS rate.

We established a CMS Web site that contains useful information regarding the IRF PPS. The Web site URL is *www.cms.hhs.gov/providers/irfpps/default.asp* and may be accessed to download or view publications, software, and other information pertinent to the IRF PPS.

B. Requirements for Updating the Prospective Payment Rates for IRFs

On August 7, 2001, we published a final rule entitled ''Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities'' in the **Federal Register** (66 FR at 41316), that established a PPS for IRFs as authorized under section 1886(j) of the Act and codified at subpart P of part 412 of the Medicare regulations. In the August 7, 2001 final rule, we set forth the per discharge Federal prospective payment rates for fiscal year (FY) 2002 that provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS. The provisions of the August 7, 2001 final rule were effective for cost reporting periods beginning on or after January 1, 2002. On July 1, 2002, we published a correcting amendment to the August 7, 2001 final rule in the **Federal Register** (67 FR at 44073). Any references to the August 7, 2001 final rule in this proposed rule include the provisions effective in the correcting amendment.

Section 1886(j)(5) of the Act and § 412.628 of the regulations require the Secretary to publish in the **Federal Register**, on or before August 1 of the preceding FY, the classifications and weighting factors for the IRF CMGs and a description of the methodology and data used in computing the prospective payment rates for the upcoming FY. On August 1, 2002, we published a notice in the **Federal Register** (67 FR at 49928) to update the IRF Federal prospective payment rates from FY 2002 to FY 2003 using the methodology as described in § 412.624. As stated in the August 1, 2002 notice, we used the same classifications and weighting factors for the IRF CMGs that were set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003. We have continued to update the prospective payment rates each year in accordance with the methodology set forth in the August 7, 2001 final rule.

In this proposed rule, we are proposing to update the IRF Federal prospective payment rates from FY 2005 to FY 2006, and we are proposing revisions to the methodology described in § 412.624. The proposed changes to the methodology are described in more detail in this proposed rule. For example, we are proposing to add a new teaching status adjustment, and we are proposing to implement other changes to existing policies in a budget neutral manner, which requires applying additional budget neutrality factors to the standard payment amount to calculate the standard payment conversion factor for FY 2006. See section III of this proposed rule for further discussion of the proposed FY 2006 Federal prospective payment rates. The proposed FY 2006 Federal prospective payment rates would be effective for discharges on or after October 1, 2005 and before October 1, 2006.

C. Operational Overview of the Current IRF PPS

As described in the August 7, 2001 final rule, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument, the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific Patient Assessment Instrument (PAI) data elements to classify (or group) the patient into a distinct CMG and account for the existence of any relevant comorbidities.

The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS Web site at *www.cms.hhs.gov/providers/irfpps/default.asp*).

Once the patient is discharged, the IRF completes the Medicare claim (UB–92 or its equivalent) using the 5-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI). (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 ASCA requires the Medicare Program, subject to subsection (H), to deny payment under Part A or Part B for any expenses for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Subsection (h) provides that the Secretary shall waive such denial in two types of cases and may also waive such denial ''in such unusual cases as the Secretary finds appropriate.'' See also, 68 FR at 48805 (August 15, 2003). Section 3 of ASCA operates in the context of the Administrative Simplification provisions of HIPAA, which include, among others, the transactions and code sets standards requirements codified as 45 CFR part 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered providers, to conduct covered electronic transactions according to the applicable

transaction standards. See the program claim memoranda issued and published by CMS at *www.cms.hhs.gov/providers/edi/default.asp, http://www.cms.hhs.gov/provider/edi/default.asp* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in section 3604 of Part 3 of the Medicare Intermediary Manual.)

The Medicare Fiscal Intermediary (FI) processes the claim through its software system. This software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments.

D. Quality of Care in IRFs

The IRF–PAI is the patient data collection instrument for IRFs. Currently, the IRF–PAI contains a blend of the functional independence measures items and quality and medical needs questions. The quality and medical needs questions (which are currently collected on a voluntary basis) may need to be modified to encapsulate those data necessary for calculation of quality indicators in the future.

We awarded a contract to the Research Triangle Institute (RTI) with the primary tasks of identifying quality indicators pertinent to the inpatient rehabilitation setting and determining what information is necessary to calculate those quality indicators. These tasks included reviewing literature and other sources for existing rehabilitation quality indicators. It also involved identifying organizations involved in measuring or monitoring quality of care in the inpatient rehabilitation setting. In addition, RTI was tasked with performing independent testing of the quality indicators identified in their research.

Once RTI has issued a final report, we will determine which quality-related items should be listed on the IRF–PAI. The revised IRF–PAI will need to be approved by OMB before it is used in IRFs.

We would like to take this opportunity to discuss our thinking related to broader initiatives in this area related to quality of care. We have supported the development of valid quality measures and have been engaged in a variety of quality improvement efforts focused in other post-acute care settings such as nursing homes. However, as mentioned above, any new quality-related data collected from the IRF–PAI would have to be analyzed to determine the feasibility of developing a payment method that accounts for the performance of the IRF in providing the necessary rehabilitative care.

Medicare beneficiaries are the primary users of IRF services. Any quality measures must be carefully constructed to address the unique characteristics of this population. Similarly, we need to consider how to design effective incentives; that is, superior performance measured against pre-established benchmarks and/or performance improvements.

In addition, while our efforts to develop the various post-acute care PPSs, including the IRF PPS, have generated substantial improvements over the preexisting cost-based systems, each of these individual systems was developed independently. As a result, we have focused on phases of a patient's illness as defined by a specific site of service, rather than on the entire post-acute episode. As the differentiation among provider types (such as SNFs and IRFs) becomes less pronounced, we need to investigate a more coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode.

This could entail a strategy of developing payment policy that is as neutral as possible regarding provider and patient decisions about the use of particular post-acute services. That is, Medicare should provide payments sufficient to ensure that beneficiaries receive high quality care in the most appropriate setting, so that admissions and any transfers between settings occur only when consistent with good care, rather than to generate additional revenues. In order to accomplish this objective, we need to collect and compare clinical data across different sites of service.

In fact, in the long run, our ability to compare clinical data across care settings is one of the benefits that will be realized as a basic component of the Department's interest in the use of a standardized electronic health record (EHR) across all settings including IRFs. It is also important to recognize the complexity of the effort, not only in developing an integrated assessment tool that is designed using health information standards, but in examining the various provider-centric prospective payment methodologies and considering payment approaches that are based on patient characteristics and outcomes. MedPAC has recently taken a preliminary look at the challenges in improving the coordination of our post-acute care payment methods, and suggested that it may be appropriate to explore additional options for paying for post-acute services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods, including the IRF PPS.

We also want to encourage incremental changes that will help us build towards these longer term objectives. For example, medical records tools are now available that could allow better coordinated discharge planning procedures. These tools can be used to ensure communication of a standardized data set that then can be used to establish a comprehensive IRF care plan. Improved communications may reduce the incidence of potentially avoidable rehospitalizations and other negative impacts on quality of care that occur when patients are transferred to IRFs without a full explanation of their care needs. We are looking at ways that Medicare providers can use these tools to generate timely data across settings.

At this time, we do not offer specific proposals related to the preceding discussion. Finally, some of the ideas discussed here may exceed our current statutory authority. However, we believe that it is useful to encourage discussion of a broad range of ideas for debate of the relative advantages and disadvantages of the various policies affecting this important component of the health care sector. We welcome comments on these and other approaches.

E. Research To Support Refinements of the Current IRF PPS

As described in the August 7, 2001 final rule, we contracted with the RAND Corporation (RAND) to analyze IRF data to support our efforts in developing the CMG patient classification system and the IRF PPS. Since then, we have continued our contract with RAND to support us in developing potential refinements to the classification system and the PPS. RAND has also developed a system to monitor the effects of the IRF PPS on patients' access to IRF care and other post-acute care services.

In 1995, RAND began extensive research, sponsored by us, on the development of a per-discharge based PPS using a patient classification system known as Functional Independence Measures-Function Related Groups (FIM–FRGs) for IRFs. The results of RAND's earliest research, using 1994

data, were released in September 1997 and are contained in two reports available through the National Technical Information Service (NTIS). The reports are: Classification System for Inpatient Rehabilitation Patients—A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, NTIS order number PB98–105992INZ, and Prospective Payment System for Inpatient Rehabilitation, NTIS order number PB98–106024INZ.

In July 1999, we contracted with RAND to update its earlier research. The update included an analysis of Functional Independence Measure (FIM) data, the Function Related Groups (FRGs), and the model rehabilitation PPS using 1996 and 1997 data. The purpose of updating the earlier research was to develop the underlying data necessary to support the Medicare IRF PPS based on CMGs for the November 3, 2000 proposed rule (65 FR at 66313). RAND expanded the scope of its earlier research to include the examination of several payment elements, such as comorbidities, facility-level adjustments, and implementation issues, including evaluation and monitoring. Then, to develop the provisions of the August 7, 2001 final rule (66 FR 41316, 41323), RAND did similar analysis on calendar year 1998 and 1999 Medicare Provider Analysis and Review (MedPAR) files and patient assessment data.

We have continued to contract with RAND to help us identify potential refinements to the IRF PPS. RAND conducted updated analyses of the patient classification system, case mix and coding changes, and facility-level adjustments for the IRF PPS using data from calendar year 2002 and FY 2003. This is the first time CMS or RAND has had data generated by IRFs after the implementation of the IRF PPS that are available for data analysis. The refinements we are proposing to make to the IRF PPS are based on the analyses and recommendations from RAND. In addition, RAND sought advice from a technical expert panel (TEP), which reviewed their methodology and findings.

F. Proposed Refinements to the IRF PPS for Fiscal Year 2006

Based on analyses by RAND using calendar year 2002 and FY 2003 data, we are proposing refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. Several new developments warrant these proposed refinements, including—(1) the availability of more recent 2002 and 2003 data; (2) better coding of comorbidities and patient severity; (3) more complete data; (4) new data sources for imputing missing values; and (5) improved statistical approaches.

In this proposed rule, we are proposing to make the following revisions:

- Reduce the standard payment amount by 1.9 percent.

In the August 7, 2001 final rule, we used cost report data from FYs 1998, 1997, and/or 1996 and calendar year 1999 Medicare bill data in calculating the initial PPS payment rates. As discussed in detail in section III.A of this proposed rule, analysis of calendar year 2002 data indicates that the standard payment conversion factor is now at least 1.9 percent higher than it should be to reflect the actual costs of caring for Medicare patients in IRFs. The data demonstrate that this is largely because the implementation of the IRF PPS caused important changes in IRFs' coding practices, including increased accuracy and consistency in coding.

- Make revisions to the comorbidity tiers and the CMGs.

In the August 7, 2001 final rule, we used FIM and Medicare data from 1998 and 1999 to construct the CMGs and to assign the comorbidity tiers. As discussed in detail in section II of this proposed rule, analysis of calendar year 2002 and FY 2003 data indicates the need to refine the comorbidity tiers and the CMGs to better reflect the costs of Medicare cases in IRFs.

- Adopt the new geographic labor market area definitions based on the definitions created by the Office of Management and Budget (OMB), known as Core-Based Statistical Areas (CBSAs), for purposes of computing the proposed wage index adjustment to IRF payments.

Historically, Medicare PPSs have used market area definitions developed by OMB. We are proposing to adopt new market area definitions which are based on OMB definitions. As discussed in detail in section III.B.2 of this proposed rule, we believe that these designations more accurately reflect the local economies and wage levels of the areas in which hospitals are located. These are the same labor market area definitions implemented for acute care inpatient hospitals under the hospital inpatient prospective payment system (IPPS) as specified in § 412.64(b)(1)(ii)(A) through (C), which were effective for those hospitals beginning October 1, 2004 as discussed in the August 11, 2004 IPPS final rule (69 FR at 49026 through 49032).

- Implement a teaching status adjustment to payments for services provided in IRFs that are, or are part of, teaching hospitals.

In previous rules, including the August 7, 2001 final rule, we noted that analyses of the data did not support a teaching adjustment. However, analysis of the more recent calendar year 2002 and fiscal year 2003 data supports a teaching status adjustment. For the first time, as discussed in detail in section III.B.3 of this proposed rule, the data analysis has demonstrated a statistically significant relationship between an IRF's teaching status and the costs of caring for patients in that IRF. We believe this may suggest the need to account for the higher costs associated with major teaching programs. For reasons discussed in detail in section III.B.3 of this proposed rule, we are proposing to implement the new teaching status adjustment in a budget neutral manner. However, we have some concerns about proposing a teaching status adjustment for IRFs at this time (as discussed in detail in section III.B.3 of this proposed rule). Because of these concerns, we are specifically soliciting comments on our consideration of an IRF teaching status adjustment.

- Update the formulas used to compute the rural and the low-income patient (LIP) adjustments to IRF payments.

In the August 7, 2001 final rule, we implemented an adjustment to account for the higher costs in rural IRFs by multiplying their payments by 1.1914. As discussed in detail in section III.B.4 of this proposed rule, the regression analysis RAND performed on fiscal year 2003 data suggests that this rural adjustment should be updated to 1.241 to account for the differences in costs between rural and urban IRFs.

Similarly, in the August 7, 2001 final rule, we implemented an adjustment to payments to reflect facilities' low-income patient percentage calculated as (1+ the disproportionate share hospital (DSH) patient percentage) raised to the power of 0.4838. As discussed in detail in section III.B.5 of this proposed rule, the regression analysis RAND performed on fiscal year 2003 data indicates that the LIP adjustment should now be calculated as (1 + DSH patient percentage) raised to the power of 0.636. For reasons discussed in detail in section III.B.5 of this proposed rule, we are proposing to implement the changes to these adjustments in a budget neutral manner.

- Update the outlier threshold amount from $11,211 (FY 2005) to $4,911 (FY 2006) to maintain total estimated outlier payments at 3 percent of total estimated payments.

In the August 7, 2001 final rule, we describe the process by which we calculate the outlier threshold, which involves simulating payments and then determining a threshold that would result in outlier payments being equal to 3 percent of total payments under the simulation. As discussed in detail in section III.B.6 of this proposed rule, we believe based on RAND's regression analysis that all of the other proposed updates to the IRF PPS, including the structure of the CMGs and the tiers, the relative weights, and the facility-level adjustments (such as the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment) make it necessary to propose to adjust the outlier threshold amount.

II. Proposed Refinements to the Patient Classification System

[If you choose to comment on issues in this section, please include the caption ''Proposed Refinements to the Patient Classification System'' at the beginning of your comments.]

A. Proposed Changes to the IRF Classification System

1. Development of the IRF Classification System

Section 1886(j)(2)(A)(i) of the Act, as amended by section 125 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 requires the Secretary to establish ''classes of patient discharges of rehabilitation facilities by functional-related groups (each referred to as a case-mix group or CMG), based on impairment, age, comorbidities, and functional capability of the patients, and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups.'' In addition, the Secretary is required to establish a method of classifying specific patients in IRFs within these groups as specified in § 412.620.

In the August 7, 2001 final rule (66 FR at 41342), we implemented a methodology to establish a patient classification system using CMGs. The CMGs are based on the FIM–FRG methodology and reflect refinements to that methodology.

In general, a patient is first placed in a major group called a rehabilitation impairment category (RIC) based on the patient's primary reason for inpatient rehabilitation, (for example, a stroke). The patient is then placed into a CMG within the RIC, based on the patient's ability to perform specific activities of daily living, and sometimes the patient's cognitive ability and/or age. Other special circumstances, such as the occurrence of very short stays, or cases where the patient expired, are also considered in determining the appropriate CMG.

We explained in the August 7, 2001 final rule that further analysis of FIM and Medicare data may result in refinements to CMGs. In the August 7, 2001 final rule, we used the most recent FIM and Medicare data available at that time (that is 1998 and 1999 data). Developing the CMGs with the 1998 and 1999 data resulted in 95 CMGs based on the FIM–FRG methodology. The data also supported the establishment of five additional special CMGs that improved the explanatory power of the FIM–FRGs. We established one additional special CMG to account for very short stays and four additional special CMGs to account for cases where the patient expired. In addition, we established a payment of an additional amount for patients with at least one relevant comorbidity in certain CMGs.

2. Description and Methodology Used to Develop the IRF Classification System in the August 7, 2001 Final Rule

a. Rehabilitation Impairment Categories

In the first step to develop the CMGs, the FIM data from 1998 and 1999 were used to group patients into RICs. Specifically, the impairment code from the assessment instrument used by clients of UDSmr and Healthsouth indicates the primary reason for the inpatient rehabilitation admission. This impairment code is used to group the patient into a RIC. Currently, we use 21 RICs for the IRF PPS.

b. Functional Status Measures and Age

After using the RIC to define the first division among the inpatient rehabilitation groups, we used functional status measures and age to partition the cases further. In the August 7, 2001 final rule, we used 1998 and 1999 Medicare bills with corresponding FIM data to create the CMGs and more thoroughly examine each item of the motor and cognitive measures. Based on the data used for the August 7, 2001 final rule, we found that we could improve upon the CMGs by making a slight modification to the motor measure. We modified the motor measure by removing the transfer to tub/shower item because we found that an increase in a patient's ability to perform functional tasks with less assistance for this item was associated with an increase in cost, whereas an increase in other functional items decreased costs. We describe below the statistical methodology (Classification and Regression Trees (CART)) that we used to incorporate a patient's functional status measures (modified motor score and cognitive score) and age into the construction of the CMGs in the August 7, 2001 final rule.

We used the CART methodology to divide the rehabilitation cases further within each RIC. (Further information regarding the CART methodology can be found in the seminal literature on CART (Classification and Regression Trees, Leo Breiman, Jerome Friedman, Richard Olshen, Charles Stone, Wadsworth Inc., Belmont CA, 1984: pp. 78–80).) We chose to use the CART method because it is useful in identifying statistical relationships among data and, using these relationships, constructing a predictive model for organizing and separating a large set of data into smaller, similar groups. Further, in constructing the CMGs, we analyzed the extent to which the independent variables (motor score, cognitive score, and age) helped predict the value of the dependent variable (the log of the cost per case). The CART methodology creates the CMGs that classify patients with clinically distinct resource needs into groups. CART is an iterative process that creates initial groups of patients and then searches for ways to divide the initial groups to decrease the clinical and cost variances further and to increase the explanatory power of the CMGs. Our current CMGs are based on historical data. In order to develop a separate CMG, we need to have data on a sufficient number of cases to develop coherent groups. Currently, we use 95 CMGs as well as 5 special CMGs for scenarios involving short stays or the expiration of the patient.

c. Comorbidities

Under the statutory authority of section 1886(j)(2)(C)(i) of the Act, we are proposing to make several changes to the comorbidity tiers associated with the CMGs for comorbidities that are not positively related to treatment costs, or their excessive use is questionable, or their condition could not be differentiated from another condition. Specifically, section 1886(j)(2)(C)(i) of the Act provides the following: The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title and other factors that may affect the relative use of resources. The adjustments shall be made in a manner so that changes in aggregate payments under the

classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis or impairment that is used to place a patient into a RIC. A patient could have one or more comorbidities present during the inpatient rehabilitation stay. Our analysis for the August 7, 2001 final rule found that the presence of a comorbidity could have a major effect on the cost of furnishing inpatient rehabilitation care. We also stated that the effect of comorbidities varied across RICs, significantly increasing the costs of patients in some RICs, while having no effect in others. Therefore, for the August 7, 2001 final rule, we linked frequently occurring comorbidities to impairment categories in order to ensure that all of the chosen comorbidities were not an inherent part of the diagnosis that assigns the patient to the RIC.

Furthermore, in the August 7, 2001 final rule, we indicated that comorbidities can affect cost per case for some of the CMGs, but not all. When comorbidities substantially increased the average cost of the CMG and were determined to be clinically relevant (not inherent in the diagnosis in the RIC), we developed CMG relative weights adjusted for comorbidities (§ 412.620(b)).

d. Development of CMG Relative Weights

Section 1886(j)(2)(B) of the Act requires that an appropriate relative weight be assigned to each CMG. Relative weights account for the variance in cost per discharge and resource utilization among the payment groups and are a primary element of a case-mix adjusted PPS. The establishment of relative weights helps ensure that beneficiaries have access to care and receive the appropriate services that are commensurate to other beneficiaries that are classified in the same CMG. In addition, prospective payments that are based on relative weights encourage provider efficiency and, hence, help ensure a fair distribution of Medicare payments. Accordingly, as specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. We discuss the details of developing the relative weights below.

As indicated in the August 7, 2001 final rule, we believe that the RAND analysis has shown that CMGs based on function-related groups (adjusted for comorbidities) are effective predictors of resource use as measured by proxies such as length of stay and costs. The use of these proxies is necessary in developing the relative weights because data that measure actual nursing and therapy time spent on patient care, and other resource use data, are not available.

e. Overview of Development of the CMG Relative Weights

As indicated in the August 7, 2001 final rule, to calculate the relative weights, we estimate operating (routine and ancillary services) and capital costs of IRFs. For this proposed rule, we use the same method for calculating the cost of a case that we outlined in the August 7, 2001 final (66 FR at 41351 through 43153). We obtained cost-to-charge ratios for ancillary services and per diem costs for routine services from the most recent available cost report data. We then obtain charges from Medicare bill data and derived corresponding functional measures from the FIM data. We omit data from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, as well as from the parameters that we use to define transfer cases, because these facilities are paid a single, negotiated rate per discharge and therefore do not maintain a charge structure. For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from cost reports. Our data analysis for the August 7, 2001 final rule showed that some departmental cost-to-charge ratios were missing or found to be outside a range of statistically valid values. For anesthesiology, a value greater than 10, or less than 0.01, is found not to be statistically valid. For all other cost centers, values greater than 10 or less than 0.5 are found not to be statistically valid. In the August 7, 2001 final rule, we replaced individual cost-to-charge ratios outside of these thresholds. The replacement value that we used for these aberrant cost-to-charge ratios was the mean value of the cost-to-charge ratio for the cost-center within the same type of hospital (either freestanding or unit). For routine services, per diem operating and capital costs are used to develop the relative weights. In addition, per diem operating and capital costs for special care services are used to develop the relative weights. (Special care services are furnished in intensive care units. We note that fewer than 1 percent of rehabilitation days are spent in intensive care units.) Per diem costs are obtained from each facility's Medicare cost report data. We use per diem costs for routine and special care services because, unlike for ancillary services, we could not obtain cost-to-charge ratios for these services from the cost report data. To estimate the costs for routine and special care services included in developing the relative weights, we sum the product of routine cost per diem and Medicare inpatient days and the product of the special care per diem and the number of Medicare special care days.

In the August 7, 2001 final rule, we used a hospital specific relative value method to calculate relative weights. We used the following basic steps to calculate the relative weights as indicated in the August 7, 2001 final rule (at 66 FR 41316, 41351 through 41352).

The first step in calculating the CMG weights is to estimate the effect that comorbidities have on costs. The second step required us to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step were used to calculate ''relative adjusted weights'' in each CMG using the hospital-specific relative value method. The final steps are to calculate the CMG relative weights by modifying the ''relative adjusted weight'' with the effects of the existence of the comorbidity tiers (explained below) and normalizing the weights to 1.

B. Proposed Changes to the Existing List of Tier Comorbidities

1. Proposed Changes to Remove Codes That Are Not Positively Related to Treatment Costs

While our methodology for this proposed rule for determining the tiers remains unchanged from the August 7, 2001 final rule, RAND's analysis indicates that 1.6 percent of FY 2003 cases received a tier payment (often in tier one) that was not justified by any higher cost for the case. Therefore, under statutory authority section 1886(j)(2)(C)(i) of the Act, we are proposing several technical changes to the comorbidity tiers associated with the CMGs. Specifically, the RAND analysis found that the first 17 diagnoses shown in Table 1 below are no longer positively related to treatment cost after controlling for CMG. The

additional two codes were also problematic. According to RAND, code 410.91 (AMI, NOS, Initial) was too unspecific to be differentiated from other related codes and code 260, Kwashiorkor, was found to be unrealistically represented in the data according to a RAND technical expert panel.

With respect to the eighteenth code in Table One, (410.X1) Specific AMI, initial), we note that RAND found there is not clinical reason to believe that this code differs in a rehabilitation environment from all of the specific codes for initial AMI of the form 410.X, where X is an numeric digit. In other words, this code is indistinguishable from the seventeenth code in Table One (410.91 AMI, NOS, initial). Following this observation, RAND tested the other initial AMI codes as a single group and found that they have no positive effect on case cost. Since we are proposing to remove ''AMI, NOS, initial'' from the tier list because it is not positively related to treatment cost after controlling for the CMG, we believe that ''Specific AMI, initial'' similarly should be removed from the tier list since it is indistinguishable from ''AMI, NOS, initial.''

With respect to the last code in Table One (Kwashiorkor), we are proposing to remove this code from the tier list as well. This comorbidity is positively related to cost in our data. However, RAND's technical expert panel (TEP) found the large number of cases coded with this rare disease to be unrealistic and recommended that it be removed from the tier list.

Table 1 contains two malnutrition codes, and removing these two malnutrition codes where use is concentrated in specific hospitals is particularly important because these hospitals are likely receiving unwarrantedly high payments due to the tier one assignment of these cases. Thus, because we believe the excess use of these two comorbid conditions is inappropriate based on the findings of RAND's TEP, we are proposing their removal.

The data indicate large variation in the rate of increase from the 1999 data to the 2003 data across the conditions that make up the tiers. The greatest increases were for miscellaneous throat conditions and malnutrition, each of which were more than 10 times as frequent in 2003 as in 1999. The growth in these two conditions was far larger than for any other condition. Many conditions, however, more than doubled in frequency, including dialysis, cachexia, obesity, and the non-renal complications of diabetes. The condition with the least growth, renal complications of diabetes, may have been affected by improved coding of dialysis.

The remaining proposed changes to our initial list of diagnoses in Table 1 deal with tracheostomy cases. These rare cases were excluded from the pulmonary RIC 15 in the August 7, 2001 final rule. The new data indicate that they are more expensive than other cases in the same CMG in RIC 15, as well as in other RICs. Therefore, we believe the data demonstrate that tracheostomy cases should be added to the tier list for RIC 15. Finally, DX V55.0, ''attention to tracheostomy'' should initially have been part of this condition as these cases were and are as expensive as other tracheostomy cases. Thus, since ''attention to tracheostomy'' is as expensive as other tracheostomy cases, it is logical to group such similar cases together.

We believe that the data provided by RAND support the removal of the codes in Table 1 below because they either have no impact on cost after controlling for their CMG or are indistinguishable from other codes or are unrealistically overrepresented. Therefore, we are proposing to remove these codes from the tier list.

TABLE 1.—PROPOSED LIST OF CODES TO BE REMOVED FROM THE TIER LIST

ICD–9–CM code	Abbreviated code title	Condition
235.1	Unc behav neo oral/phar	Miscellaneous throat conditions.
933.1	Foreign body in larynx	Miscellaneous throat conditions.
934.1	Foreign body bronchus	Miscellaneous throat conditions.
530.0	Achalasia & cardiospasm	Esophegeal conditions.
530.3	Esophageal stricture	Esophegeal conditions.
530.6	Acquired esophag diverticulum	Esophegeal conditions.
V46.1	Dependence on respirator	Ventilator status.
799.4	Cachexia	Cachexia.
V49.75	Status amputation below knee	Amputation of LE.
V49.76	Status amputation above knee	Amputation of LE.
V497.7	Status amputation hip	Amputation of LE.
356.4	Idiopathic progressive polyneuropathy	Meningitis and encephalitis.
250.90	Diabetes II, w unspecified complications, not stated as uncontrolled	Non-renal Complications of Diabetes.
250.93	Diabetes I, w unspecified complications, uncontrolled	Non-renal Complications of Diabetes.
261	Nutritional Marasmus	Malnutrition.
262	Other severe protein calorie deficiency	Malnutrition.
410.91	AMI, NOS, initial	Major comorbidities.
410.X1	Specific AMI, initial	Major comorbidities.
260	Kwashiorkor	Malnutrition.

2. Proposed Changes To Move Dialysis To Tier One

We are proposing the movement of dialysis to tier one, which is the tier associated with the highest payment. The data from the RAND analysis show that patients on dialysis cost substantially more than current payments for these patients and should be moved into the highest paid tier because this tier would more closely align payment with the cost of a case. Based on RAND's analysis using 2003 data, a patient with dialysis costs 31 percent more than a non-dialysis patient in the same CMG and with the same other accompanying comorbidities.

Overall, the largest increase in the cost of a condition occurs among patients on dialysis, where the coefficient in the cost regression increases by 93 percent, from 0.1400 to 0.2697. Part of the explanation for the increased coefficient could be that some IRFs had not borne all dialysis costs for their patients in the pre-PPS period

(because providers were previously permitted to bill for dialysis separately). Dialysis is currently in tier two. However, it is likely that, in the 1999 data, some IRFs had not borne all dialysis costs for their patients. Because the fraction of cases coded with dialysis increased by 170 percent, it is also likely that improved coding was part of the explanation for the increased coefficient. We believe a 170 percent increase is such a dramatic increase that it would be highly unlikely that in one short time, 170 percent more patients need dialysis than they did before the implementation of the IRF PPS. We also believe that the improved coding is likely due to the fact that higher costs are associated with dialysis patients and therefore IRFs, in an effort to ensure that their payments cover these higher expenses will better and more carefully code comorbidities whose presence will result in higher PPS payments.

Moving dialysis patients to tier one will more adequately compensate hospitals for the extra cost of those patients and thereby maintain or increase access to these services.

3. Proposed Changes To Move Comorbidity Codes Based on Their Marginal Cost

Under statutory authority section 1886(j)(2)(C)(i) of the Act, we are proposing to move comorbidity codes based on their marginal cost. Another limitation with the existing tiers is that costs for several conditions would be more accurately predicted if their tier assignments were changed. After examining RAND's data, we believe that a full 4 percent of FY 2003 cases should be moved down to tiers with lower payment.

We propose that tier assignments be based on the results of statistical analyses RAND has performed under contract with CMS, using as independent variables only the proposed CMGs and conditions that we are proposing for tiers (for example, the CMGs and conditions that remain after the proposed changes have been made). We are proposing that the tier assignments of each of these conditions be decided based on the magnitude of their coefficients in RAND's statistical analysis.

We believe the IRF PPS led to substantial changes in coding of comorbidities between 1999 (pre-implementation of the IRF PPS) and 2003 (post-implementation of the IRF PPS). The percentage of cases with one or more comorbidities increased from 16.79 percent in the data in which tiers were defined (1998 through 1999) to 25.51 percent in FY 2003. This is an increase of 52 percent in tier incidence ($52 = 100 \times (25.51 - 16.79)/16.79$). The presence of a tier one comorbidity, the highest paid of the tiers, almost quadrupled during this same time period. Although, coding likely improved, the presence of upcoding for a higher payment may play a factor as well.

The 2003 data provide a more accurate explanation of the costs that are associated with each of the comorbidities, largely due to having 100 percent of the Medicare-covered IRF cases in the later data versus slightly more than half of the cases in 1999 data. Therefore, using the 2003 data to propose to assign each diagnosis or condition will considerably improve the matching of payments to their relative costs.

C. Proposed Changes to the CMGs

Section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors of patients under the IRF PPS to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made, and other factors that may affect the relative use of resources. These adjustments shall be made in a manner so that changes in aggregate payments under the classification system are the result of real changes and not the result of changes in coding that are unrelated to real changes in case mix.

In accordance with section 1886(j)(2)(C)(i) of the Act and as specified in § 412.620(c) and based on the research conducted by RAND, we are proposing to update the CMGs used to classify IRF patients for purposes of establishing payment amounts. We are also proposing to update the relative weights associated with the payment groups based on FY 2003 Medicare bill and patient assessment data. We are proposing to replace the current unweighted motor score index used to assign patients to CMGs with a weighted motor score index that would improve our ability to accurately predict the costs of caring for IRF patients, as described in detail below. However, we are not proposing to change the methodology for computing the cognitive score index.

As described in the August 7, 2001 final rule, we contracted with RAND to analyze IRF data to support our efforts in developing our patient classification system and the IRF PPS. We have continued our contract with RAND to support us in developing potential refinements to the classification system and the PPS. As part of this research, we asked RAND to examine possible refinements to the CMGs to identify potential improvements in the alignment between Medicare payments and actual IRF costs. In conducting its research, RAND used a technical expert panel (TEP) made up of experts from industry groups, other government entities, academia, and other interested parties. The technical expert panel reviewed RAND's methodologies and advised RAND on many technical issues.

Several recent developments make significant improvements in the alignment between Medicare payments and actual IRF costs possible. First, when the IRF PPS was implemented in 2002, a new recording instrument was used to collect patient data, the IRF Patient Assessment Instrument (or the IRF PAI). The new instrument contained questions that improved the quality of the patient-level information available to researchers.

Second, more recent data are available on a larger patient population. Until now, the design of the IRF PPS was based entirely on 1999 data on Medicare rehabilitation patients from just a sample of hospitals. Now, we have post-PPS data from 2002 and 2003 that describe the entire universe of Medicare-covered rehabilitation patients.

Finally, we believe that proposed improvements in the algorithms that produced the initial CMGs, as described below, should lead to new CMGs that better predict treatment costs in the IRF PPS.

Using FIM (the inpatient rehabilitation facility assessment instrument before the PPS) and Medicare data from 1998 and 1999, RAND helped us develop the original structure of the IRF PPS. IRFs became subject to the PPS beginning with cost reporting periods on or after January 1, 2002. The PPS is based on assigning patients to particular CMGs that are designed to predict the costs of treating particular Medicare patients according to how well they function in four general categories: transfers, sphincter control, self-care (for example, grooming, eating), and locomotion. Patient functioning is measured according to 18 categories of activity: 13 motor tasks, such as climbing stairs, and 5 cognitive tasks, such as recall. The PPS is intended to align payments to IRFs as closely as possible with the actual costs of treating patients. If the PPS ''underpays'' for some kinds of care, IRFs have incentives to limit access for patients requiring that kind of care because payments would be less than the costs of providing care for a particular case so an IRF may try to

limit its financial ''losses''; conversely, if the PPS overpays, resources are wasted because IRFs' payments exceed the costs of providing care for a particular case.

The fiscal year 2003 data file currently available for refining the CMGs is better than the 1999 data RAND originally used to construct the IRF PPS because it contains many more IRF cases and represents the universe of Medicare-covered IRF cases, rather than a sample. The best available data that CMS and RAND had for analysis in 1999 contained 390,048 IRF cases, representing 64 percent of all Medicare-covered patients in participating IRF hospitals. The more recent data contain 523,338 IRF cases (fiscal year 2003), representing all Medicare-covered patients in participating IRF hospitals. The larger file enables RAND to obtain greater precision in the analysis and ensures a more balanced and complete picture of patients under the IRF PPS.

Also, the fiscal year 2003 data are better than the 1999 data used to design the IRF PPS because they include more detailed information about patients' level of functioning. For example, new variables are included in the more recent data that provide further details on patient functioning. Standard bowel and bladder scores on the FIM instrument (used to assess patients before the IRF PPS), for example, measured some combination of the level of assistance required and the frequency of accidents (that is, soiling of clothes and surroundings). New variables on the IRF–PAI instrument measure the level and the frequency separately. Since measures of the level of assistance required and the frequency of accidents contain slightly different information about the expected costliness of an IRF patient, having measures for these two variables separately provides additional information to researchers.

Furthermore, additional optional information is recorded on the health status of patients in the more recent data (for example, shortness of breath, presence of ulcers, inability to balance).

1. Proposed Changes for Updating the CMGs

As described in the August 7, 2001 final rule, RAND developed the original list of CMGs using FIM data from 1998 and 1999 to group patients into RICs. Table 2 below shows the final set of 95 CMGs based on the FIM–FRG methodology, the 5 special CMGs, and their descriptions. Impairment codes from the assessment instrument used by UDSmr and Healthsouth indicated the primary reasons for inpatient rehabilitation admissions. The impairment codes were used to group patients into RICs. Table 3 below shows each RIC and its associated impairment code.

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Table 2--Definition of Case Mix Groups (CMGs) From the August 7, 2001 Final Rule

CMG Number	CMG Description
101	Stroke with motor score from 69-84 and cognitive score from 23-35
102	Stroke with motor score from 59-68 and cognitive score from 23-35
103	Stroke with motor score from 59-84 and cognitive score from 5-22
104	Stroke with motor score from 53-58
105	Stroke with motor score from 47-52
106	Stroke with motor score from 42-46
107	Stroke with motor score from 39-41
108	Stroke with motor score from 34-38 and patient is 83 years old or older
109	Stroke with motor score from 34-38 and patient is 82 years old or younger
110	Stroke with motor score from 12-33 and patient is 89 years old or older
111	Stroke with motor score from 27-33 and patient is between 82 and 88 years old
112	Stroke with motor score from 12-26 and patient is between 82 and 88 years old
113	Stroke with motor score from 27-33 and patient is 81 years old or younger
114	Stroke with motor score from 12-26 and patient is 81 years old or younger
201	Traumatic brain injury with motor score from 52-84 and cognitive score from 24-35
202	Traumatic brain injury with motor score from 40-51 and cognitive score from 24-35
203	Traumatic brain injury with motor score from 40-84 and cognitive score from 5-23

CMG Number	CMG Description
204	Traumatic brain injury with motor score from 30-39
205	Traumatic brain injury with motor score from 12-29
301	Non-traumatic brain injury with motor score from 51-84
302	Non-traumatic brain injury with motor score from 41-50
303	Non-traumatic brain injury with motor score from 25-40
304	Non-traumatic brain injury with motor score from 12-24
401	Traumatic spinal cord injury with motor score from 50-84
402	Traumatic spinal cord injury with motor score from 36-49
403	Traumatic spinal cord injury with motor score from 19-35
404	Traumatic spinal cord injury with motor score from 12-18
501	Non-traumatic spinal cord injury with motor score from 51-84 and cognitive score from 30-35
502	Non-traumatic spinal cord injury with motor score from 51-84 and cognitive score from 5-29
503	Non-traumatic spinal cord injury with motor score from 41-50
504	Non-traumatic spinal cord injury with motor score from 34-40
505	Non-traumatic spinal cord injury with motor score from 12-33
601	Neurological with motor score from 56-84
602	Neurological with motor score from 47-55
603	Neurological with motor score from 36-46
604	Neurological with motor score from 12-35
701	Fracture of lower extremity with motor score from 52-84
702	Fracture of lower extremity with motor score from 46-51

CMG Number	CMG Description
703	Fracture of lower extremity with motor score from 42-45
704	Fracture of lower extremity with motor score from 38-41
705	Fracture of lower extremity with motor score from 12-37
801	Replacement of lower extremity joint with motor score from 58-84
802	Replacement of lower extremity joint with motor score from 55-57
803	Replacement of lower extremity joint with motor score from 47-54
804	Replacement of lower extremity joint with motor score from 12-46 and cognitive score from 32-35
805	Replacement of lower extremity joint with motor score from 40-46 and cognitive score from 5-31
806	Replacement of lower extremity joint with motor score from 12-39 and cognitive score from 5-31
901	Other orthopedic with motor score from 54-84
902	Other orthopedic with motor score from 47-53
903	Other orthopedic with motor score from 38-46
904	Other orthopedic with motor score from 12-37
1001	Amputation, lower extremity with motor score from 61-84
1002	Amputation, lower extremity with motor score from 52-60
1003	Amputation, lower extremity with motor score from 46-51
1004	Amputation, lower extremity with motor score from 39-45
1005	Amputation, lower extremity with motor score from 12-38
1101	Amputation, non-lower extremity with motor score from 52-84

CMG Number	CMG Description
1102	Amputation, non-lower extremity with motor score from 38-51
1103	Amputation, non-lower extremity with motor score from 12-37
1201	Osteoarthritis with motor score from 55-84 and cognitive score from 34-35
1202	Osteoarthritis with motor score from 55-84 and cognitive score from 5-33
1203	Osteoarthritis with motor score from 48-54
1204	Osteoarthritis with motor score from 39-47
1205	Osteoarthritis with motor score from 12-38
1301	Rheumatoid, other arthritis with motor score from 54-84
1302	Rheumatoid, other arthritis with motor score from 47-53
1303	Rheumatoid, other arthritis with motor score from 36-46
1304	Rheumatoid, other arthritis with motor score from 12-35
1401	Cardiac with motor score from 56-84
1402	Cardiac with motor score from 48-55
1403	Cardiac with motor score from 38-47
1404	Cardiac with motor score from 12-37
1501	Pulmonary with motor score from 61-84
1502	Pulmonary with motor score from 48-60
1503	Pulmonary with motor score from 36-47
1504	Pulmonary with motor score from 12-35
1601	Pain syndrome with motor score from 45-84
1602	Pain syndrome with motor score from 12-44
1701	Major multiple trauma without brain or spinal cord injury with motor score from 46-84
1702	Major multiple trauma without brain or spinal cord injury with motor score from 33-45
1703	Major multiple trauma without brain or spinal cord injury with motor score from 12-32
1801	Major multiple trauma with brain or spinal cord injury with motor score from 45-84 and cognitive score from 33-35

CMG Number	CMG Description
1802	Major multiple trauma with brain or spinal cord injury with motor score from 45-84 and cognitive score from 5-32
1803	Major multiple trauma with brain or spinal cord injury with motor score from 26-44
1804	Major multiple trauma with brain or spinal cord injury with motor score from 12-25
1901	Guillian Barre with motor score from 47-84
1902	Guillian Barre with motor score from 31-46
1903	Guillian Barre with motor score from 12-30
2001	Miscellaneous with motor score from 54-84
2002	Miscellaneous with motor score from 45-53
2003	Miscellaneous with motor score from 33-44
2004	Miscellaneous with motor score from 12-32 and patient is 82 years old or older
2005	Miscellaneous with motor score from 12-32 and patient is 81 years old or younger
2101	Burns with motor score from 46-84
2102	Burns with motor score from 12-45
5001	Short-stay cases, length of stay is 3 days or fewer
5101	Expired, orthopedic, length of stay is 13 days or fewer
5102	Expired, orthopedic, length of stay is 14 days or more
5103	Expired, not orthopedic, length of stay is 15 days or fewer
5104	Expired, not orthopedic, length of stay is 16 days or more

Table 3—Rehabilitation Impairment Categories (RICs) and Associated Impairment Group Codes From the August 7, 2001 Final Rule

Rehabilitation Impairment Category (RIC)	Associated Impairment Group Codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain) 01.2 Right body involvement (left brain) 01.3 Bilateral Involvement 01.4 No Paresis 01.9 Other Stroke
02 Traumatic brain injury (TBI)	02.21 Open Injury 02.22 Closed Injury
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic 02.9 Other Brain
04 Traumatic spinal cord injury (TSCI)	04.210 Paraplegia, Unspecified 04.211 Paraplegia, Incomplete 04.212 Paraplegia, Complete 04.220 Quadriplegia, Unspecified 04.2211 Quadriplegia, Incomplete C1-4 04.2212 Quadriplegia, Incomplete C5-8 04.2221 Quadriplegia, Complete C1-4 04.2222 Quadriplegia, Complete C5-8 04.230 Other traumatic spinal cord dysfunction
05 Nontraumatic spinal cord injury (NTSCI)	04.110 Paraplegia, unspecified 04.111 Paraplegia, incomplete 04.112 Paraplegia, complete 04.120 Quadriplegia, unspecified 04.1211 Quadriplegia, Incomplete C1-4 04.1212 Quadriplegia, Incomplete C5-8 04.1221 Quadriplegia, Complete C1-4 04.1222 Quadriplegia, Complete C5-8 04.130 Other non-traumatic spinal cord dysfunction

Rehabilitation Impairment Category (RIC)	**Associated Impairment Group Codes**
06 Neurological (Neuro)	03.1 Multiple Sclerosis 03.2 Parkinsonism 03.3 Polyneuropathy 03.5 Cerebral Palsy 03.8 Neuromuscular Disorders 03.9 Other Neurologic
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture 08.12 Status post bilateral hip fractures 08.2 Status post femur (shaft) fracture 08.3 Status post pelvic fracture
08 Replacement of LE joint (Rep1LE)	08.51 Status post unilateral hip replacement 08.52 Status post bilateral hip replacements 08.61 Status post unilateral knee replacement 08.62 Status post bilateral knee replacements 08.71 Status post knee and hip replacements (same side) 08.72 Status post knee and hip replacements (different sides)
09 Other orthopedic(Ortho)	08.9 Other orthopedic
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK) 05.4 Unilateral lower extremity below the knee (BK) 05.5 Bilateral lower extremity above the knee (AK/AK) 05.6 Bilateral lower extremity above/below the knee (AK/BK) 05.7 Bilateral lower extremity below the knee (BK/BK)
11 Amputation, other (AMP-NLE)	05.1 Unilateral upper extremity above the elbow (AE) 05.2 Unilateral upper extremity below the elbow (BE) 05.9 Other amputation
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis

Rehabilitation Impairment Category (RIC)	Associated Impairment Group Codes
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis 06.9 Other arthritis
14 Cardiac (Cardiac)	09 Cardiac
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease 10.9 Other pulmonary
16 Pain Syndrome (Pain)	07.1 Neck pain 07.2 Back pain 07.3 Extremity pain 07.9 Other pain
17 Major multiple trauma, no brain injury or spinal cord injury (MMT-NBSCI)	08.4 Status post major multiple fractures 14.9 Other multiple trauma
18 Major multiple trauma, with brain or spinal cord injury (MMT-BSCI)	14.1 Brain and spinal cord injury 14.2 Brain and multiple fractures/amputation 14.3 Spinal cord and multiple fractures/amputation
19 Guillian Barre (GB)	03.4
20 Miscellaneous (Misc)	12.1 Spina Bifida 12.9 Other congenital 13 Other disabling impairments 15 Developmental disability 16 Debility 17.1 Infection 17.2 Neoplasms 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition 17.4 Circulatory disorders 17.51 Respiratory disorders-Ventilator Dependent 17.52 Respiratory disorders-Non-ventilator Dependent 17.6 Terminal care 17.7 Skin disorders 17.8 Medical/Surgical complications 17.9 Other medically complex conditions
21 Burns (Burns)	11 Burns

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Given the availability of more recent, post-PPS data, we asked RAND to examine possible refinements to the CMGs to identify potential

improvements in the alignment between Medicare payments and actual IRF costs. In addition to analyzing fiscal year 2003 data, RAND also convened a TEP, made up of researchers from industry, provider organizations, government, and academia, to provide support and guidance through the process of developing possible refinements to the PPS. Members of the TEP reviewed drafts of RAND's reports, offered suggestions for additional analyses, and provided clinicians' views of the importance and significance of various findings.

RAND's analysis of the FY 2003 data, along with the support and guidance of the TEP, strongly suggest the need to update the CMGs to better align payments with costs under the IRF PPS. The other option we considered before deciding to propose to update the CMGs with the fiscal year 2003 data was to maintain the same CMG structure but recalculate the relative weights for the current CMGs using the 2003 data. After carefully reviewing the results of RAND's regression analysis, which compared the predictive ability of the CMGs under 3 scenarios (not updating the CMGs or the relative weights, updating only the relative weights and not the CMGs, and updating both the relative weights and the CMGs), we believe (based on RAND's analysis) that updating both the relative weights and the CMGs will allow the classification system to do a much better job of reflecting changes in treatment patterns, technology, case mix, and other factors which may affect the relative use of resources.

We believe it is appropriate to update the CMGs and the relative weights at this time because the 2003 data we now have represent a substantial improvement over the 1999 data. The more recent data include all Medicare-covered IRF cases rather than a subset, allowing us to base the proposed CMG changes on a complete picture of the types of patients in IRFs. In designing the IRF PPS, we used the best available data, but those data did not allow us to have a complete picture of the types of patients in IRFs. Also, the clinical coding of patient conditions in IRFs is vastly improved in the more recent data than it was in the best available data we had to design the IRF PPS. In addition, changes in treatment patterns, technology, case mix, and other factors affecting the relative use of resources in IRFs since the IRF PPS was implemented likely require an update to the classification system.

We are currently paying IRFs based on 95 CMGs and 5 special CMGs developed using the CART algorithm applied to 1999 data. The CART algorithm that was used in designing the IRF PPS assigned patients to RICs according to their age and their motor and cognitive FIM scores. CART produced the partitions so that the reported wage-adjusted rehabilitation cost of the patients was relatively constant within partitions. Then, a subjective decision-making process was used to decrease the number of CMGs (to ensure that the payment system did not become unduly complicated), to enforce certain constraints on the CMGs (to ensure that, for instance, IRFs were not paid more for patients who had fewer comorbidities than for patients with more comorbidities), and to fit the comorbidity tiers. Although the use of a subjective decision-making process (rather than a computer algorithm) was very useful, there were limitations. For example, it made it difficult to explore the implications of variations to the CART models because a computer program can examine many more variations of a model in a much shorter time than an individual person. Furthermore, the computer is more efficient at accounting for all of the possible combinations and interactions between important variables that affect patient costs.

In analyzing potential refinements to the IRF PPS, RAND created a new algorithm that would be very useful in constructing the proposed CMGs (the new algorithm would be based on the CART methodology described in detail earlier in this section of the proposed rule). RAND applied the new algorithm to the fiscal year 2003 IRF data. We are proposing to use RAND's new algorithm for refinements to the CMGs. The proposed algorithm would be based entirely on an iterative computerized process to decrease the number of CMGs, enforce constraints on the CMGs, and assign the comorbidity tiers. At each step in the process, the proposed new CART algorithm would produce all of the possible combinations of CMGs using all available variables. It would then select the variables and the CMG constructions that offer the best predictive ability, as measured by the greatest decrease in the mean-squared error. We propose that the following constraints be placed on the algorithm, based on RAND's analysis: (1) Neighboring CMGs would have to differ by at least $1,500, unless eliminating the CMG would change the estimated costs of patients in that CMG by more than $1,000; (2) estimated costs for patients with lower motor or cognitive index scores (more functionally dependent) would always have to be higher than estimated costs for patients with higher motor or cognitive index scores (less functionally dependent). We believe that the PPS should not pay more for a patient who is less functionally dependent than for one who is more functionally dependent; and (3) each CMG must contain at least 50 observations (for statistical validity).

RAND's technical expert panel, which included representatives from industry groups, other government entities, academia, and other researchers, reviewed and commented on these constraints and the rest of RAND's proposed methodology (developed based on RAND's analysis of the data) for updating the CMGs as RAND developed the improvements to the CART methodology.

The following would be the most substantial differences between the existing CMGs and the proposed new CMGs:

- Fewer CMGs than before (87 compared with 95 in the current system).
- The number of CMGs under the RIC for stroke patients (RIC 1) would decrease from 14 to 10.
- The cognitive index score would affect patient classification in two of the RICs (RICs 1 and 2), whereas it currently affects RICs 1, 2, 5, 8, 12, and 18.
- A patient's age would now affect assignment for CMGs in RICs 1, 4 and 8, whereas it currently affects assignment for CMGs in RICs 1 and 4.

In Table 2 above, we provided the CMGs that are currently being used to pay IRFs. Table 4 below shows the proposed new CMGs.

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Table 4—Proposed New Case Mix Groups (CMGs), With the Associated Rehabilitation Impairment Categories (RICs)

RIC	CMG Number	CMG Description
01 Stroke (Stroke)	0101	Motor >51.05
	0102	Motor >44.45 & Motor <51.05 & Cognitive >18.5
	0103	Motor >44.45 & Motor <51.05 & Cognitive <18.5
	0104	Motor >38.85 & Motor <44.45
	0105	Motor >34.25 & Motor <38.85
	0106	Motor >30.05 & Motor <34.25
	0107	Motor >26.15 & Motor <30.05
	0108	Motor <26.15 & Age >84.5
	0109	Motor >22.35 & Motor <26.15 & Age <84.5
	0110	Motor <22.35 & Age <84.5
02 Traumatic brain injury (TBI)	0201	Motor >53.35 & Cognitive >23.5
	0202	Motor >44.25 & Motor <53.35 & Cognitive >23.5
	0203	Motor >44.25 & Cognitive <23.5
	0204	Motor >40.65 & Motor <44.25
	0205	Motor >28.75 & Motor <40.65
	0206	Motor >22.05 & Motor <28.75
	0207	Motor <22.05
03 Nontraumatic brain injury (NTBI)	0301	Motor >41.05
	0302	Motor >35.05 & Motor <41.05

RIC	CMG Number	CMG Description
03 Nontraumatic brain injury (NTBI)	0303	Motor >26.15 & Motor <35.05
	0304	Motor <26.15
04 Traumatic spinal cord injury (TSCI)	0401	Motor >48.45
	0402	Motor >30.35 & Motor <48.45
	0403	Motor >16.05 & Motor <30.35
	0404	Motor <16.05 & Age >63.5
	0405	Motor <16.05 & Age <63.5
05 Nontraumatic spinal cord injury (NTSCI)	0501	Motor >51.35
	0502	Motor >40.15 & Motor <51.35
	0503	Motor >31.25 & Motor <40.15
	0504	Motor >29.25 & Motor <31.25
	0505	Motor >23.75 & Motor <29.25
	0506	Motor <23.75
06 Neurological (Neuro)	0601	Motor >47.75
	0602	Motor >37.35 & Motor <47.75
	0603	Motor >25.85 & Motor <37.35
	0604	Motor <25.85
07 Fracture of LE (FracLE)	0701	Motor >42.15
	0702	Motor >34.15 & Motor <42.15
	0703	Motor >28.15 & Motor <34.15
	0704	Motor <28.15
08 Replacement of LE joint (RepLE)	0801	Motor >49.55
	0802	Motor >37.05 & Motor <49.55
	0803	Motor >28.65 & Motor <37.05 & Age >83.5
08 Replacement of LE joint (RepLE)	0804	Motor >28.65 & Motor <37.05 & Age <83.5

RIC	CMG Number	CMG Description
	0805	Motor >22.05 & Motor <28.65
	0806	Motor <22.05
09 Other orthopedic(Ortho)	0901	Motor >44.75
	0902	Motor >34.35 & Motor <44.75
	0903	Motor >24.15 & Motor <34.35
	0904	Motor <24.15
10 Amputation, lower extremity (AMPLE)	1001	Motor >47.65
	1002	Motor >36.25 & Motor <47.65
	1003	Motor <36.25
11 Amputation, other (AMP-NLE)	1101	Motor >36.35
	1102	Motor <36.35
12 Osteoarthritis (OsteoA)	1201	Motor >37.65
	1202	Motor >30.75 & Motor <37.65
	1203	Motor <30.75
13 Rheumatoid, other arthritis (RheumA)	1301	Motor >36.35
	1302	Motor >26.15 & Motor <36.35
	1303	Motor <26.15
14 Cardiac (Cardiac)	1401	Motor >48.85
	1402	Motor >38.55 & Motor <48.85
	1403	Motor >31.15 & Motor <38.55
	1404	Motor <31.15
15 Pulmonary (Pulmonary)	1501	Motor >49.25
	1502	Motor >39.05 & Motor <49.25
	1503	Motor >29.15 & Motor <39.05
	1504	Motor <29.15
16 Pain Syndrome (Pain)	1601	Motor >37.15
16 Pain Syndrome (Pain)	1602	Motor >26.75 & Motor <37.15
	1603	Motor <26.75

RIC	CMG Number	CMG Description
17 Major multiple trauma, no brain injury or spinal cord injury (MMT-NBSCI)	1701	Motor >39.25
	1702	Motor >31.05 & Motor <39.25
	1703	Motor >25.55 & Motor <31.05
	1704	Motor <25.55
18 Major multiple trauma, with brain or spinal cord injury (MMT-BSCI)	1801	Motor >40.85
	1802	Motor >23.05 & Motor <40.85
	1803	Motor <23.05
19 Guillian Barre (GB)	1901	Motor >35.95
	1902	Motor >18.05 & Motor <35.95
	1903	Motor <18.05
20 Miscellaneous (Misc)	2001	Motor >49.15
	2002	Motor >38.75 & Motor <49.15
	2003	Motor >27.85 & Motor <38.75
	2004	Motor <27.85
21 Burns (Burns)	2101	Motor >0

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Note: CMG definitions use proposed weighted motor scores, as defined below.

The primary objective in updating the CMGs is to better align IRF payments with the costs of caring for IRF patients, given better, more recent information. This requires that we improve the ability of the system to predict patient costs. RAND's analysis suggests that the proposed new CMGs clearly improve the ability of the payment system to predict patient costs. The proposed new CMGs would greatly improve the explanation of the variance in the system.

2. Proposed Use of a Weighted Motor Score Index and Correction to the Treatment of Unobserved Transfer to Toilet Values

As described in detail below, we are proposing to use a weighted motor score index in assigning patients to CMGs, instead of the current motor score index that treats all components equally. We are also proposing to change the motor score value for the transfer to toilet variable to 2 rather than 1 when it is unobserved. However, we are not proposing changes to the cognitive score index. As described in detail below, we believe that a weighted motor score index, with the correction to the treatment of unobserved transfer to toilet values would improve the classification of patients into CMGs, which in turn would improve the accuracy of payments to IRFs.

In order to classify a patient into a CMG, IRFs use the admission assessment data from the IRF–PAI to score a patient's functional independence measures. The functional independence measures consist of what are termed ''motor'' items and ''cognitive'' items. In addition to the functional independence measures, the patient's age may also influence the patient's CMG classification. The motor items are generally indications of the patient's physical functioning level. The cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. The motor items are eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, walking or wheelchair use, and stair climbing. The cognitive items are comprehension, expression, social interaction, problem solving, and memory. (The CMS IRF–PAI manual includes more information on these items.) Each item is generally recorded on a patient assessment instrument and scored on a scale of 1 to 7, with a 7 indicating complete independence in this area of functioning, and a 1 indicating that a patient is very impaired in this area of functioning.

As explained in the August 7, 2001 final rule (66 FR at 41349), the

instructions for the IRF–PAI require that providers record an 8 for an item to indicate that the activity did not occur (or was not observed), as opposed to a 1 through 7 indicating that the activity occurred and the estimated level of function connected with that activity.

Please note that when the IRF–PAI form went through the approval process, the code 8 was removed and replaced with the code 0. Therefore, a 0 is now the code facilities use to record when an activity does not occur (or is not observed).

In order to determine the appropriate payment for patients for whom an activity is coded as 0 (that is, either not performed or not observed), we needed to decide an appropriate way of changing the 0 to another code for which payment could be assigned. As discussed in the August 7, 2001 final rule (66 FR at 41349), we decided to assign a code of 1 (indicating that the patient needed ''maximal assistance'') whenever a code of 0 appeared for one of the items on the IRF–PAI used to determine payment. This was the most conservative approach we could have taken based on the best available data at the time because a value of 1 indicates that the patient needed maximal assistance performing the task. Thus, providers would receive the highest payment available for that item (although it might not be the highest payment overall, depending on the patient's CMG, other functional abilities, and/or comorbidities).

We are proposing to change the way we treat a code of 0 on the IRF–PAI for the transfer to toilet item. This is the only item for which we are proposing this change at this time because RAND's regression analysis demonstrated that of all the motor score values, the evidence supporting a change in the motor score values was the strongest with respect to this item. We propose to assign a code of 2, instead of a code of 1, to patients for whom a 0 is recorded on the IRF–PAI for the transfer to toilet item (as discussed below) because RAND's analysis of calendar year 2002 and FY 2003 data indicates that patients for whom a 0 is recorded are more similar in terms of their characteristics and costliness to patients with a recorded score of 2 than to patients with a recorded score of 1. We are proposing to make this change in order to provide the most accurate payment for each patient.

Using regression analysis on the calendar year 2002 and FY 2003 data, which is more complete and provides more detailed information on patients' functional abilities than the FY 1999 data used to construct the IRF PPS (even though the 1999 data were the best available data at the time), RAND analyzed whether the assignment of 1 to items for which a 0 is recorded on the IRF–PAI continues to correctly assign payments based on patients' expected costliness. RAND examined all of the items in the motor score index, focusing on how often a code of 0 appears for the item, how similar patients with a code of 0 are to other patients with the same characteristics that have a score of 1 though 7, and how much a change in the item's score affects the prediction of a patient's expected costliness. Based on RAND's regression analysis, we believe it is appropriate to change the assignment of 0 on the transfer to toilet item from a 1 to a 2 for the purposes of determining IRF payments.

Until now, the IRF PPS has used standard motor and cognitive scores, the sum of either 12 or 13 motor items and the sum of 5 cognitive items, to assign patients to CMGs. This summing equally weights the components of the indices. These indices have been accepted and used for many years. Although the weighted motor score is an option that has been considered before, most experts believed that the data were not complete and accurate enough before the IRF PPS (although they were the most complete and accurate data available at the time). Now, it is believed that the data are complete and accurate enough to support proposing to use a weighted motor score index.

In developing candidate indices that would weight the items in the score, RAND had competing goals: to develop indices that would increase the predictive power of the system while at the same time maintaining simplicity and transparency in the payment system. For example, they found that an ''optimal'' weighting methodology from the standpoint of predictive power would require computing 378 different weights (18 different weights for the motor and cognitive indices that could all differ across 21 RICs). Rather than introduce this level of complexity to the system, RAND decided to explore simpler weighting methodologies that would still increase the predictive power of the system.

RAND used regression analysis to explore the relationship of the FIM motor and cognitive scores to cost. The idea of these models was to determine the impact of each of the FIM items on cost and then weight each item in the index according to its relative impact on cost. Based on the regression analysis, RAND was able to design a weighting methodology for the motor score that could potentially be applied uniformly across all RICs.

RAND assessed different weighting methodologies for both the motor score index and the cognitive score index. They discovered that weighting the motor score index improved the predictive ability of the system, whereas weighting the cognitive score index did not. Furthermore, the cognitive score index has never had much of an effect (in some RICs, it has no effect) on the assignment of patients to CMGs because the motor score tends to be much stronger at predicting a patient's expected costs in an IRF than the cognitive score.

For these reasons, we are proposing a weighting methodology for the motor score index at this time. We propose to continue using the same methodology we have been using since the IRF PPS was first implemented to compute the cognitive score index (that is, summing the components of the index) because, among other things, a change in methodology for calculating this component of the system failed to improve the accuracy of the IRF PPS payments. Therefore, it would be futile to expend resources on changing this method when it would not benefit the program.

Table 5 below shows the proposed optimal weights for the components of the motor score, averaged across all RICs and normalized to sum to 100.0, obtained through the regression analysis. The weights relate to the FIM items' relative ability to predict treatment costs. Table 5 indicates that dressing lower, toilet, bathing, and eating are the most effective self-care items for predicting costs; bowel and bladder control may not be effective at predicting costs; and that the items grouped in the transfer and locomotion categories might be somewhat more effective at predicting costs than the other categories.

TABLE 5.—PROPOSED OPTIMAL WEIGHTS, AVERAGED ACROSS REHABILITATION IMPAIRMENT CATEGORIES (RICS): MOTOR ITEMS

Item type	Functional independence item	Average optimal weight
Self	Dressing lower	1.4
Self	Toilet	1.2
Self	Bathing	0.9
Self	Eating	0.6
Self	Dressing upper	0.2
Self	Grooming	0.2
Sphincter	Bladder	0.5
Sphincter	Bowel	0.2
Transfer	Transfer to bed	2.2
Transfer	Transfer to toilet	1.4
Transfer	Transfer to tub	Not included

TABLE 5.—PROPOSED OPTIMAL WEIGHTS, AVERAGED ACROSS REHABILITATION IMPAIRMENT CATEGORIES (RICS): MOTOR ITEMS—Continued

Item type	Functional independence item	Average optimal weight
Locomotion ..	Walking	1.6
Locomotion ..	Stairs	1.6

Based on RAND's analysis, we considered a number of different candidate indices before proposing a weighted index. We considered proposing to define some simple combinations of the four item types that make up the motor score index and assigning weights to the groups of items instead of to the individual items. For example, we considered proposing to sum the three transfer items together to form a group with a weight of two, since they contributed about twice as much in the cost regression as the self-care items. We also considered proposing to assign the self-care items a weight of one and the bladder and bowel items as a group a weight close to zero, since they contributed little to predicting cost in the regression analysis. We tried a number of variations and combinations of this, but RAND's TEP generally rejected these weighting schemes. They believed that introducing elements of subjectivity into the development of the weighting scheme may invite controversy, and that it is better to use an objective algorithm to derive the appropriate weights. We agree that an objective weighting scheme is best because it is based on regression analysis of the amount that various components of the motor score index contribute to predicting patient costs, using the best available data we have. Therefore, we are proposing a weighting scheme that applies the average optimal weights. To develop the proposed weighting scheme, RAND used regression analysis to estimate the relative contribution of each item to the prediction of costs. Based on this analysis, we are proposing to use the weighting scheme indicated in Table 5 above and in the following simple equation:

Motor score index=1.4*dressing lower + 1.2*toilet + 0.9*bathing + 0.6*eating + 0.2*dressing upper + 0.2*grooming + 0.5*bladder + 0.2*bowel + 2.2*transfer to bed + 1.4*transfer to toilet + 1.6*walking + 1.6*stairs.

Another reason we are proposing to use a weighted motor score index to assign patients to CMGs is that RAND's regression analysis showed that it predicts costs better than the current unweighted motor score index. Across all 21 RICs, the proposed weighted motor score index improves the explanation of variance within each RIC by 9.5 percent, on average.

3. Proposed Changes for Updating the Relative Weights

Section 1886(j)(2)(B) of the Act requires that an appropriate relative weight be assigned to each CMG. Relative weights that account for the variance in cost per discharge and resource utilization among payment groups are a primary element of a case-mix adjusted prospective payment system. The accuracy of the relative weights helps to ensure that payments reflect as much as possible the relative costs of IRF patients and, therefore, that beneficiaries have access to care and receive the appropriate services.

Section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment to IRFs is made, and other factors which may affect the relative use of resources. In accordance with this section of the Act, we are proposing to recalculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, would cost twice as much as cases in a CMG with a relative weight of 1. We are not proposing any changes to the methodology we are using for calculating the relative weights, as described in the August 7, 2001 final rule (66 FR 41316, 41351 through 41353); we are only proposing to update the relative weights themselves.

As previously stated, we believe that improved coding of data, the availability of more complete data, proposed changes to the tier comorbidities and CMGs, and changes in IRF cost structures make it very unlikely that the relative weights assigned to the CMGs when the IRF PPS was first implemented still accurately represent the differences in costs across CMGs and across tiers. Therefore, we are proposing to recalculate the relative weights. However, we are not proposing any changes to the methodology for calculating the relative weights. Instead, we are proposing to update the relative weights (the relative weights that are multiplied by the standard payment conversion factor to assign relative payments for each CMG and tier) using the same methodology as described in the August 7, 2001 final rule (66 FR 41316, 41351 through 41353) and as described in detail at the beginning of this section of this proposed rule, applied to FY 2003 Medicare billing data. To summarize, we are proposing to use the following basic steps to update the relative weights: The first step in calculating the CMG weights is to estimate the effects that comorbidities have on costs. The second step is to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step are used to calculate ''relative adjusted weights'' in each CMG using the hospital-specific relative value method. The final steps are to calculate the CMG relative weights by modifying the ''relative adjusted weight'' with the effects of the existence of the comorbidity tiers (explained below) and normalize the weights to 1. Table 6 below shows the proposed relative weights, based on the 2003 data.

Table 6 - Proposed Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M>51.05	0.7691	0.7299	0.6484	0.6350	8	11	9	8
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9471	0.8989	0.7985	0.7820	11	14	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1162	1.0594	0.9411	0.9217	13	20	11	12
0104	Stroke M>38.85 and M<44.45	1.1859	1.1255	0.9999	0.9792	12	13	13	13
0105	Stroke M>34.25 and M<38.85	1.4233	1.3509	1.2001	1.1753	15	16	15	15
0106	Stroke M>30.05 and M<34.25	1.6567	1.5724	1.3969	1.3680	16	20	17	17
0107	Stroke M>26.15 and M<30.05	1.9121	1.8148	1.6122	1.5790	18	22	19	19
0108	Stroke M<26.15 and A>84.5	2.2106	2.0981	1.8639	1.8254	22	23	19	19
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.1976	2.0858	1.8529	1.8147	20	23	21	21
0110	Stroke M<22.35 and A<84.5	2.6262	2.4926	2.2143	2.1686	23	28	22	23
0201	Traumatic brain injury M>53.35 and C>23.5	0.8140	0.6826	0.6021	0.5648	10	9	9	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0437	0.8753	0.7720	0.7241	17	10	11	9
0203	Traumatic brain injury M>44.25 and C<23.5	1.2487	1.0472	0.9236	0.8664	13	14	11	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.3356	1.1201	0.9879	0.9267	14	14	12	12
0205	Traumatic brain injury M>28.75 and M<40.65	1.6381	1.3738	1.2116	1.1365	16	17	15	14

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0206	Traumatic brain injury M>22.05 and M<28.75	2.1379	1.7930	1.5814	1.4833	19	19	18	17
0207	Traumatic brain injury M<22.05	2.7657	2.3194	2.0457	1.9188	28	23	21	20
0301	Non-traumatic brain injury M>41.05	1.1293	0.9536	0.8440	0.7764	12	11	10	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.4729	1.2438	1.1008	1.0126	14	15	13	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.7575	1.4841	1.3136	1.2083	18	17	15	15
0304	Non-traumatic brain injury M<26.15	2.4221	2.0453	1.8103	1.6651	24	21	19	18
0401	Traumatic spinal cord injury M>48.45	0.9891	0.8517	0.7656	0.6837	7	12	10	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3640	1.1746	1.0558	0.9428	17	16	14	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.3743	2.0446	1.8379	1.6412	21	22	20	20
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.2567	3.6656	3.2950	2.9424	37	36	28	28
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.2477	2.7967	2.5139	2.2449	25	34	27	24
0501	Non-traumatic spinal cord injury M>51.35	0.7705	0.6449	0.5641	0.5059	14	7	8	7
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0316	0.8634	0.7553	0.6774	13	12	10	9

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3676	1.1446	1.0013	0.8979	14	15	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.7120	1.4328	1.2534	1.1240	20	18	15	14
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0289	1.6981	1.4855	1.3321	20	20	17	16
0506	Non-traumatic spinal cord injury M<23.75	2.7607	2.3106	2.0212	1.8126	21	24	21	20
0601	Neurological M>47.75	0.8965	0.7331	0.6966	0.6493	10	10	9	9
0602	Neurological M>37.35 and M<47.75	1.1925	0.9752	0.9267	0.8636	13	13	12	12
0603	Neurological M>25.85 and M<37.35	1.5266	1.2484	1.1863	1.1056	15	16	14	14
0604	Neurological M<25.85	1.9539	1.5979	1.5183	1.4151	17	18	18	17
0701	Fracture of lower extremity M>42.15	0.9055	0.7736	0.7265	0.6585	11	11	9	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1757	1.0044	0.9432	0.8549	13	13	12	11
0703	Fracture of lower extremity M>28.15 and M<34.15	1.4636	1.2504	1.1742	1.0643	15	16	15	14
0704	Fracture of lower extremity M<28.15	1.7962	1.5345	1.4410	1.3062	16	18	17	16
0801	Replacement of lower extremity joint M>49.55	0.6561	0.5511	0.5109	0.4596	7	7	7	6
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8570	0.7198	0.6673	0.6004	9	10	9	8

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0672	0.9894	0.8901	17	15	12	11
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1069	0.9296	0.8618	0.7754	13	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3937	1.1705	1.0852	0.9763	16	15	13	12
0806	Replacement of lower extremity joint M<22.05	1.6726	1.4047	1.3023	1.1716	15	17	15	14
0901	Other orthopedic M>44.75	0.8412	0.7658	0.6805	0.6090	10	11	10	8
0902	Other orthopedic M>34.35 and M<44.75	1.1054	1.0063	0.8942	0.8002	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4583	1.3276	1.1797	1.0557	16	17	15	14
0904	Other orthopedic M<24.15	1.8281	1.6643	1.4788	1.3234	19	20	17	17
1001	Amputation, lower extremity M>47.65	0.9638	0.8888	0.7931	0.7312	11	10	10	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1719	1.0457	0.9641	14	14	13	12
1003	Amputation, lower extremity M<36.25	1.7876	1.6483	1.4709	1.3561	16	19	17	16
1101	Amputation, non-lower extremity M>36.35	1.2544	1.0496	0.9189	0.8462	13	14	11	11

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1102	Amputation, non-lower extremity M<36.35	1.8780	1.5713	1.3756	1.2668	16	16	16	15
1201	Osteoarthritis M>37.65	1.0184	0.8794	0.8106	0.7317	11	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.3181	1.1383	1.0492	0.9470	13	15	13	13
1203	Osteoarthritis M<30.75	1.6238	1.4022	1.2925	1.1666	17	16	16	15
1301	Rheumatoid, other arthritis M>36.35	1.0338	0.9617	0.8325	0.7358	11	12	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4324	1.3325	1.1534	1.0195	15	17	14	13
1303	Rheumatoid, other arthritis M<26.15	1.8308	1.7032	1.4743	1.3032	18	19	17	16
1401	Cardiac M>48.85	0.8172	0.7352	0.6396	0.5806	9	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1034	0.9926	0.8636	0.7839	11	13	11	10
1403	Cardiac M>31.15 and M<38.55	1.3735	1.2356	1.0750	0.9759	14	15	13	12
1404	Cardiac M<31.15	1.7419	1.5671	1.3633	1.2376	17	18	15	14
1501	Pulmonary M>49.25	0.9222	0.8995	0.7687	0.7397	8	12	10	10
1502	Pulmonary M>39.05 and M<49.25	1.1659	1.1371	0.9718	0.9352	11	14	12	12
1503	Pulmonary M>29.15 and M<39.05	1.4269	1.3917	1.1894	1.1445	11	15	14	14
1504	Pulmonary M<29.15	1.8812	1.8348	1.5681	1.5089	18	18	16	14
1601	Pain syndrome M>37.15	1.0065	0.8544	0.7731	0.6904	12	10	10	9
1602	Pain syndrome M>26.75 and M<37.15	1.3810	1.1724	1.0607	0.9473	12	16	13	12
1603	Pain syndrome M<26.75	1.6988	1.4421	1.3048	1.1653	18	17	15	14

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1701	Major multiple trauma without brain or spinal cord injury M>39.25	1.0102	0.9634	0.8323	0.7321	12	11	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.3305	1.2688	1.0962	0.9643	14	16	14	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5832	1.5098	1.3043	1.1474	16	19	16	15
1704	Major multiple trauma without brain or spinal cord injury M<25.55	1.9808	1.8889	1.6319	1.4355	23	22	19	17
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.2118	0.9832	0.8245	0.7282	20	16	12	9
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9385	1.5728	1.3190	1.1649	20	21	17	15
1803	Major multiple trauma with brain or spinal cord injury M<23.05	3.4784	2.8222	2.3668	2.0903	30	25	25	22
1901	Guillian Barre M>35.95	1.2362	1.0981	1.0677	0.9349	12	14	13	12
1902	Guillian Barre M>18.05 and M<35.95	2.3162	2.0574	2.0004	1.7515	28	24	22	22
1903	Guillian Barre M<18.05	3.3439	2.9703	2.8881	2.5287	27	29	25	27
2001	Miscellaneous M>49.15	0.8743	0.7387	0.6623	0.6047	9	10	9	8

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
2002	Miscellaneous M>38.75 and M<49.15	1.1448	0.9672	0.8671	0.7917	12	12	11	10
2003	Miscellaneous M>27.85 and M<38.75	1.4789	1.2495	1.1202	1.0227	15	15	14	13
2004	Miscellaneous M<27.85	1.9756	1.6692	1.4964	1.3663	19	18	17	15
2101	Burns M>0	2.1858	2.1858	1.5910	1.4762	26	20	17	16
5001	Short-stay cases, length of stay is 3 days or fewer				0.2201				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.6002				22
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.7204				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8771				24

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We are proposing to make the tier and the CMG changes in such a way that total estimated aggregate payments to IRFs for FY 2006 are the same with and without the proposed changes (that is, in a budget neutral manner) for the following reasons. First, we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. Furthermore, RAND did not find evidence that the overall costliness of patients (average case mix) in IRFs increased substantially in 2002 compared with 1999. As discussed in detail in section III.A of this proposed rule, RAND found that real case mix increased by at most 1.5 percent, and may have decreased by as much as 2.4 percent. The available evidence, therefore, suggests that resources in the IRF PPS are likely adequate to care for the types of patients IRFs treat. We are open to examining other evidence regarding the amount of aggregate payments in the system and the types of patients IRFs are currently treating.

The purpose of the CMG and tier changes is to ensure that the existing resources already in the IRF PPS are distributed better among IRFs according to the relative costliness of the types of patient they treat. Section 1886(j)(2)(C)(i) of the Act confers broad statutory authority upon the Secretary to adjust the classification and weighting factors in order to account for relative resource use. Consistent with that broad statutory authority, we are proposing to redistribute aggregate payments to more accurately reflect the IRF case mix.

To ensure that total estimated aggregate payments to IRFs do not change, we propose to apply a factor to the standard payment amount to ensure that estimated aggregate payments under this subsection in the FY are not greater or less than those that would

have been made in the year without such adjustment. In section III.B.7 and section III.B.8 of this proposed rule, we discuss the methodology and factor we are proposing to apply to the standard payment amount.

III. Proposed FY 2006 Federal Prospective Payment Rates

(If you choose to comment on issues in this section, please include the caption ''Proposed FY 2006 Federal Prospective Payment Rates'' at the beginning of your comments.)

A. Proposed Reduction of the Standard Payment Amount to Account for Coding Changes

Section 1886(j)(2)(C)(ii) of the Act requires the Secretary to adjust the per payment unit payment rate for IRF services to eliminate the effect of coding or classification changes that do not reflect real changes in case mix if the Secretary determines that changes in coding or classification of patients have resulted or will result in changes in aggregate payments under the classification system. As described below, in accordance with this section of the Act and based on research conducted by RAND under contract with us, we are proposing to reduce the standard payment amount for patients treated in IRFs by 1.9 percent. However, as discussed below, RAND found a range of possible estimates that likely accounts for the amount of case mix change that was due to coding. In light of the range of estimates that may be appropriate, we are continuing to work with RAND to further analyze the data and are considering adoption of an alternative percentage reduction. Accordingly, we solicit comments on whether the proposed 1.9 percent is the percentage reduction that ought to be made, or if another percentage reduction (for example, the 3.4 percent observed case mix change or the 5.8 percent that RAND found in its study, detailed below, to be the maximum amount of change due to coding) should be applied.

We are proposing to reduce the standard payment amount by 1.9 percent because RAND's regression analysis of calendar year 2002 data found that payments to IRFs were about $140 million more than expected during 2002 because of changes in the classification of patients in IRFs, and that a portion of this increase in payments was due to coding changes that do not reflect real changes in case mix. If IRF patients have more costly impairments, lower functional status, or more comorbidities, and thus require more resources in the IRF in 2002 than in 1999, we would consider this a real change in case mix. Conversely, if IRF patients have the same impairments, functional status, and comorbidities in 2002 as they did in 1999 but are coded differently resulting in higher payment, we consider this a case mix increase due to coding. We believe that changes in payment amounts should accurately reflect changes in IRFs' patient case mix (that is, the true cost of treating patients), and should not be influenced by changes in coding practices.

Under the IRF PPS, payments for each Medicare rehabilitation patient are determined using a multi-step process. First, a patient is assigned to a particular CMG and a tier based on four patient characteristics at admission: impairment, functional independence, comorbidities, and age. The amount of the payment for each patient is then calculated by taking the standard payment conversion factor ($12,958 in FY 2005) and adjusting it by multiplying by a relative weight, which depends on each patient's CMG and tier assignment.

For example, an 80-year old hip replacement patient with a motor score between 47 and 54 and no comorbidities would be assigned to a particular CMG and tier based on these characteristics. The CMG and tier to which he is assigned would have an associated relative weight, in this case 0.5511 in FY 2005 (69 FR at 45725). This relative weight would be multiplied by the standard payment conversion factor of $12,958 to equal the payment of $7,141 in FY 2005 ($0.5511 \times \$12{,}958 = \$7{,}141$). Based on the following discussion, we are proposing lowering the standard payment amount by 1.9 percent to account for coding changes that have increased payments to IRFs. However, we solicit comments regarding other possible percentage reductions within the range RAND identified, as discussed below.

As described in the August 7, 2001 final rule, we contracted with RAND to analyze IRF data to support our efforts in developing the classification system and the IRF PPS. We have continued our contract with RAND to support us in developing potential refinements to the classification system and the PPS for this proposed rule. As part of this research, we asked RAND to examine changes in case mix and coding since the IRF PPS. To examine these changes, RAND compared 2002 data from the first year of implementation of the PPS with the 1999 (pre-PPS) data used to construct the IRF PPS.

RAND's analysis of the 2002 data, as described in more detail below, demonstrates that changes in the types of patients going to IRFs and changes in coding both caused increases in payments to IRFs between 1999 and 2002. The 2002 data are more complete than the 1999 data that were first used to design the IRF PPS because they include all Medicare-covered IRF cases. Although the 1999 data we used in designing the original standard payment rate for the IRF PPS were the best available data we had at the time, they were based on a sample (64 percent) of IRF cases.

In addition, such review was necessary because, as explained below, we believe that the implementation of the IRF PPS caused important changes in coding. The IRF PPS likely improved the accuracy and consistency of coding across IRFs, because of the educational programs that were implemented in 2001 and 2002 and because items that previously did not affect payments (such as comorbidities) became important factors for determining the PPS payments. Since these items now affect payments, there is greater incentive to code for them. There were also changes to the IRF–PAI instructions given for coding some of the items on the patient assessment instrument, so that the same patient may have been correctly coded differently in 2002 than in 1999.

Furthermore, implementation of the IRF PPS may have caused changes in case mix because it increased incentives for IRFs to take patients with greater impairment, lower function, or comorbidities. Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248), IRFs were paid on the basis of Medicare reasonable costs limited by a facility-specific target amount per discharge. IRFs were paid on a per discharge basis without per discharge adjustments being made for the impairments, functional status, or comorbidities of patients. Thus, IRFs had a strong incentive to admit less costly patients to ensure that the costs of treating patients did not exceed their TEFRA payments. Under the IRF PPS, however, IRFs' PPS payments are tied directly to the principle diagnosis and accompanying comorbidities of the patient. Thus, based on the characteristics of the patients (that is, impairments, functional status, and comorbidities), the more costly the patient is expected to be, the higher the PPS payment. Therefore, IRFs may have greater incentives than they had under TEFRA to admit more costly patients.

Thus, in light of these concerns, RAND performed an analysis using IRF Medicare claims data matched with FIM and IRF–PAI data and comparing 2002 data (post-PPS) with 1999 data (pre-

PPS), RAND found that the observed case mix—the expected costliness of patients—in IRFs increased by 3.4 percent between the two time periods. Thus, we paid 3.4 percent, or about $140 million, more than expected during 2002 because of changes in the classification of cases in IRFs. However, RAND found little evidence that the patients admitted to IRFs in 2002 had higher resource needs (that is, more impairments, lower functioning, or more comorbidities) than the patients admitted in 1999. In fact, most of the changes in case mix that RAND documented from the acute care hospital records implied that IRF patients should have been less costly to treat in 2002 than in 1999. For example, RAND found a 16 percent decrease in the proportion of patients treated in IRFs following acute hospitalizations for stroke, when it compared the results of the 2002 data with the 1999 data. Stroke patients tend to be relatively more costly than other types of patients for IRFs because they tend to require more intensive services than other types of patients. A decrease in the proportion of stroke patients relative to other types of patients, therefore, would likely contribute to a decrease in the overall expected costliness of IRF patients. RAND also found a 22 percent increase in the proportion of cases treated in IRFs following a lower extremity joint replacement. Lower extremity joint replacement patients tend to be relatively less costly for IRFs than other types of patients because their care needs tend to be less intensive than other types of patients. For this reason, the increase in the proportion of these patients treated in IRFs would suggest a decrease in the overall expected costliness of IRF patients.

We asked RAND to quantify the amount of the case mix change that was due to real case mix change (that is, the extent to which IRF patients had more impairments, lower functioning, or more comorbidities) and the amount that was due to coding. However, while the data permit RAND to observe the total change in expected costliness of patients over time with some precision, estimating the amount of this total change that is real and the amount that is due to coding generally cannot be done with the same level of precision. Therefore, in order to quantify the amounts that were due to real case mix change and the amounts that were due to coding, RAND used two approaches to give a range of estimates within which the correct estimates would logically fall—(1) one that potentially underestimates the amount of real case mix change and overestimates the amount of case mix change due to coding; and (2) one that potentially overestimates real change and underestimates change due to coding. These two approaches give us a range of estimates, which we are confident should logically border the actual amount of real case mix and coding change. The first approach uses the following assumptions:

- Changes over time in characteristics recorded during the acute hospitalizations preceding the inpatient rehabilitation facility stay were real case mix changes (as acute care hospitals had little incentive to change their coding of patients in response to the IRF PPS); and
- Changes over time in IRF coding that did not correspond with changes in the characteristics recorded during the acute hospitalizations were attributable to changes in IRF coding practices.

To illustrate this point, suppose, for example, that the IRF records showed that there were a greater number of patients with a pulmonary condition in IRFs in 2002 than in 1999. Patients with a pulmonary condition tend to be relatively more costly for IRFs to treat than other types of patients, so an increase in the number of these patients would indicate an increase in the costliness of IRF patients (that is, an increase in IRFs' case mix). However, in 2002 IRFs had a much greater incentive to record if patients had a pulmonary condition than they did in 1999 because they got paid more for this condition in 2002, whereas they did not in 1999. Therefore, it is reasonable to expect that some of the increase in the number of patients with a pulmonary condition was due to the fact that IRFs were recording that condition for patients more frequently, not that there were really more patients of that type (although there may also have been some more patients of that type). To determine the extent to which IRFs may have just been coding that condition more often versus the extent to which there actually may have been more patients with a pulmonary condition going to IRFs than before, RAND looked at the one source of information that we believe was least likely to be influenced by the incentive to code patients with this condition more frequently in the IRF: the acute care hospital record from the stay preceding the IRF stay. We believe that the acute care hospitals are not likely to be influenced by IRF PPS policies that only affect IRF payments (that is, changes in IRF payment policies would not likely result in monetary benefits to the acute care hospitals). Thus, if RAND found a substantial increase in the number of IRF patients with a pulmonary condition in the acute care hospital before going to the IRF, it would be reasonable to assume that more patients with a pulmonary condition were going to IRFs (a real increase in case mix). However, if there was little change in the number of IRF patients with a pulmonary condition in the acute care hospital before going to the IRF, then we believe it is reasonable to assume that a portion of the increase in patients with a pulmonary condition in IRFs was due to the incentives to code more of these patients in the IRFs.

We believe that this first approach shows that both factors, real case mix change and coding change, contributed to the amount of observed change in 2002, the first IRF PPS rate year. However, these estimates (based on the best available data) do not fully address all of the variables that may have contributed to the change in case mix. For example, the model does not account for the possibility that patients could develop impairments, functional problems, or comorbidities after they leave the acute care hospital (prior to the IRF admission) that would make them more costly when they are in the IRF. We note that the introduction of a new payment system may have interrelated effects on providers as they adapt to new (or perceived) program incentives. Thus, an analysis of first year experience may not be fully representative of providers' behavior under a fully implemented system. In addition, hospital coding practices may change at a different rate in facilities where the IRF is a unit of an acute care hospital compared with freestanding IRF hospitals. Although we attempted to identify all of the factors that cause the variation in costs among the IRFs' patient population, this may not have been possible given that the data are from the transitional year of the new PPS. Finally, we want to ensure that the rate reduction will not have an adverse effect on beneficiaries' access to IRF care.

For the reasons described above, we believe we should provide some flexibility to account for the possibility that some of the observed changes may be attributable to other than coding changes. Thus, in determining the amount of the proposed reduction in the standard payment amount, we examined RAND's second approach that recognizes the difficulty of precise measurement of real case mix and coding changes. Using this second approach, RAND developed an analytical procedure that allowed them to distinguish more fully between real case mix change and coding change

based on patient characteristics. In part, this second approach involves analyzing some specific examples of coding that we know have changed over time, such as direct indications of improvements in impairment coding, changes in coding instruction for bladder and bowel functioning, and dramatic increases in coding of certain conditions that affect patients' placement into tiers (resulting in higher payments).

Using the two approaches, RAND found that real case mix changes in IRFs over this period ranged from a decrease of 2.4 percent (using the first approach) to an increase of 1.5 percent (using the second approach). This suggests that coding changes accounted for between 1.9 percent (if real case mix increased by 1.5 percent (that is, 3.4 percent minus 1.5 percent)) and 5.8 percent (if real case mix decreased by 2.4 percent (that is, 3.4 percent plus 2.4 percent)) of the increase in aggregate payments for 2002 compared with 1999. Thus, RAND recommended decreasing the standard per discharge payment amount by between 1.9 and 5.8 percent to adjust for the coding changes. We are proposing to reduce the standard payment amount by the lower of these two numbers, 1.9 percent, because we believe it is a reasonable estimate for the amount of coding change, based on RAND's analysis of direct indications of coding change.

We considered proposing a reduction to the standard payment amount by an amount up to 5.8 percent because RAND's first approach suggested that coding changes could possibly have been responsible for up to 5.8 percent of the observed increase in IRFs' case mix. Furthermore, a separate analysis by RAND found that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. This suggests that we could potentially have proposed a reduction greater than 1.9 and up to 5.8 percent.

We decided to propose a reduction of 1.9 percent, the lowest possible amount of change attributable to coding change. However, we are continuing to work with RAND to further analyze the data and are soliciting comments on the following factors which may have an effect on the amount of the reduction. First, whether changes that occurred within the transitional IRF PPS rate year could have impacted coding and patient selection and affected these analyses. Second, since we feel it is crucial to maintain access to IRF care, we are soliciting comments on the effect of the proposed range of reductions on access to IRF care, particularly for patients with greater resource needs. The analyses described here are only the first of an ongoing series of studies to evaluate the existence and extent of payment increases due to coding changes. We will continue to review the need for any further reduction in the standard payment amount in subsequent years as part of our overall monitoring and evaluation of the IRF PPS.

Therefore, for FY 2006, we are proposing to reduce the standard payment amount by the lowest amount (1.9 percent) attributable to coding changes. We believe this approach, which is supported by RAND's analysis of the data, would adequately adjust for the increased payments to IRFs caused by purely coding changes, but would still provide the flexibility to account for the possibility that some of the observed changes in case mix may be attributed to other than coding changes. Furthermore, we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the ''75 percent rule.'' We are continuing to work with RAND to analyze the data and are soliciting comments on whether the proposed 1.9 percent is the percentage reduction that ought to be made, or if another percentage reduction (for example, the 3.4 percent observed case mix change or the 5.8 percent that RAND found to be maximum amount of change due to coding) should be applied.

To accomplish the proposed reduction of the standard payment conversion factor by 1.9 percent, we first propose to update the FY 2005 standard payment conversion factor by the estimated market basket of 3.1 percent to get the standard payment amount for FY 2006 ($12,958*1.031 = $13,360). Next, we propose to multiply the FY 2006 standard payment amount by 0.981, which reduces the standard payment amount by 1.9 percent ($13,360*0.981 = $13,106). In section III.B.7 of this proposed rule, we propose to further adjust the $13,106 by the proposed budget neutrality factors for the wage index and the other proposed refinements outlined in this proposed rule that would result in the proposed FY 2006 standard payment conversion factor. In section III.B.7 of this proposed rule, we provide a step-by-step calculation that results in the FY 2006 standard payment conversion factor.

B. Proposed Adjustments to Determine the Proposed FY 2006 Standard Payment Conversion Factor

1. Proposed Market Basket Used for IRF Market Basket Index

Under the broad authority of section 1886(j)(3)(C) of the Act, the Secretary establishes an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in covered IRF services, which is referred to as a market basket index. The market basket needs to include both operating and capital. Thus, although the Secretary is required to develop an increase factor under section 1886(j)(3)(C) of the Act, this provision gives the Secretary discretion in the design of such factor.

The index currently used to update payments for rehabilitation facilities is the Excluded hospital including capital market basket. This market basket is based on 1997 Medicare cost report data and includes Medicare-participating rehabilitation (IRF), LTCH, psychiatric (IPF), cancer, and children's hospitals.

We are unable to create a separate market basket specifically for rehabilitation hospitals due to the small number of facilities and the limited data that are provided (for instance, only about 25 percent of rehabilitation facility cost reports reported contract labor cost data for 2002). Since all IRFs are paid under the IRF PPS, nearly all LTCHs are paid under the LTCH PPS, and IPFs for cost reporting periods beginning on or after January 1, 2005 will be paid under the IPF PPS, we propose to update payments for rehabilitation facilities using a market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs, hereafter referred to as the RPL (rehabilitation, psychiatric, long-term care) market basket. We propose to exclude children's and cancer hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. They are not reimbursed under a prospective payment system. Also, the FY 2002 cost structures for children's and cancer hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. The services offered in IRFs, IPFs, and LTCHs are typically more labor-intensive than those offered in cancer and children's hospitals. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer and children's hospitals. In addition, the depreciation cost weights

for IRFs, IPFs, and LTCHs are noticeably smaller than those for children's and cancer hospitals.

In the following discussion, we provide a background on market baskets and describe the methodologies used to determine the operating and capital portions of the proposed FY 2002-based RPL market basket.

a. Overview of the Proposed RPL Market Basket

The proposed RPL market basket is a fixed weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected (in this case, FY 2002), and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are price levels derived from publicly available statistical series that are published on a consistent schedule, preferably at least on a quarterly basis.

Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy for a given period. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that time period.

A market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. In this manner, the market basket measures only the pure price change. Only when the index is rebased would the quantity and intensity effects be captured in the cost weights. Therefore, we rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish patient care between base periods.

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, shifting the base year cost structure from FY 1997 to FY 2002). Revising means changing data sources, methodology, or price proxies used in the input price index. We are proposing to rebase and revise the market basket used to update the IRF PPS.

b. Proposed Methodology for Operating Portion of the Proposed RPL Market Basket

The operating portion of the proposed FY 2002-based RPL market basket consists of several major cost categories derived from the FY 2002 Medicare cost reports for IRFs, IPFs, and LTCHs: Wages, drugs, professional liability insurance and a residual. We choose FY 2002 as the base year because we believe this is the most recent, relatively complete year of Medicare cost report data. Due to insufficient Medicare cost report data for IRFs, IPFs, and LTCHs, cost weights for benefits, contract labor, and blood and blood products were developed using the proposed FY 2002-based IPPS market basket (Section IV. Proposed Rebasing and Revision of the Hospital Market Baskets IPPS Hospital Proposed Rule for FY 2006), which we explain in more detail later in this section. For example, less than 30 percent of IRFs, IPFs, and LTCHs reported benefit cost data in FY 2002. We have noticed an increase in cost data for these expense categories over the last 4 years. The next time we rebase the RPL market basket, there may be sufficient IRFs, IPFs, and LTCHs cost report data to develop the weights for these expenditure categories.

Since the cost weights for the RPL market basket are based on facility costs, we are proposing to limit our sample to hospitals with a Medicare average length of stay within a comparable range of the total facility average length of stay. We believe this provides a more accurate reflection of the structure of costs for Medicare treatments. Our goal is to measure cost shares that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries.

We propose to use those cost reports for IRFs and LTCHs whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay for the hospital. This is the same edit applied to the FY 1992 and FY 1997 excluded hospital with capital market baskets. We propose 15 percent because it includes those LTCHs and IRFs whose Medicare LOS is within approximately 5 days of the facility length of stay.

We propose to use a less stringent measure of Medicare length of stay for IPFs whose average length of stay is within 30 or 50 percent (depending on the total facility average length of stay) of the total facility length of stay. This less stringent edit allows us to increase our sample size by over 150 reports and produce a cost weight more consistent with the overall facility. The edit we applied to IPFs when developing the FY–1997 based excluded hospital with capital market basket was based on the best available data at the time.

The detailed cost categories under the residual (that is, the remaining portion of the market basket after excluding wages and salaries, drugs, and professional liability cost weights) are derived from the proposed FY 2002-based IPPS market basket and the 1997 Benchmark Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. The proposed FY 2002-based IPPS market basket is developed using FY 2002 Medicare hospital cost reports with the most recent and detailed cost data. The 1997 Benchmark I–O is the most recent, comprehensive source of cost data for all hospitals. Proposed cost weights for benefits, contract labor, and blood and blood products were derived using the proposed FY 2002-based IPPS market basket. For example, the ratio of the benefit cost weight to the wages and salaries cost weight in the proposed FY 2002-based IPPS market basket was applied to the RPL wages and salaries cost weight to derive a benefit cost weight for the RPL market basket. The remaining proposed operating cost categories were derived using the 1997 Benchmark Input-Output Tables aged to 2002 using relative price changes. (The methodology we used to age the data involves applying the annual price changes from the price proxies to the appropriate cost categories. We repeat this practice for each year.) Therefore, using this methodology roughly 59 percent of the proposed RPL market basket is accounted for by wages, drugs and professional liability insurance data from FY 2002 Medicare cost report data for IRFs, LTCHs, and IPFs.

Table 7 below sets forth the complete proposed FY 2002-based RPL market basket including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 1997-based excluded hospital with capital market basket is listed as well.

Wages and salaries are 52.895 percent of total costs for the proposed FY 2002-based RPL market basket compared to 47.335 percent for FY 1997-based excluded hospital with capital market basket. Employee benefits are 12.982 percent for the proposed FY 2002-based RPL market basket compared to 10.244 percent for FY 1997-based excluded hospital with capital market basket. As a result, compensation costs (wages and salaries plus employee benefits) for the proposed FY 2002-based RPL market basket are 65.877 percent of costs compared to 57.579 percent for the FY 1997-based excluded hospital with capital market basket. Of the 8 percentage point difference between the compensation shares, approximately 3 percentage points are due to the proposed new base year (FY 2002 instead of FY 1997), 3 percentage points are due to the revised length of stay edit and the remaining 2 percentage points are due to the proposed exclusion of other hospitals (that is, only including IRFs, IPFs, and LTCHs in the market basket).

Following the table is a summary outlining the choice of the proxies used for the operating portion of the proposed market basket. The price proxies for the proposed capital portion are described in more detail in the capital methodology section. (See section III.B.1.c of this proposed rule.)

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Table 7 - Proposed FY 2002-based RPL Market Basket Cost Categories, Weights and Proxies With FY 1997-based Excluded Hospital With Capital Market Basket Used for Comparison

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	Proposed FY 2002-based RPL Market Basket	Proposed FY 2002 RPL Market Basket Price Proxies
TOTAL	100.000	100.000	
Compensation	57.579	65.877	
Wages and Salaries*	47.335	52.895	ECI-Wages and Salaries, Civilian Hospital Workers
Employee Benefits*	10.244	12.982	ECI-Benefits, Civilian Hospital Workers
Professional fees Non-Medical*	4.423	2.892	ECI - Compensation for Professional, Specialty & Technical Workers
Utilities	1.180	0.656	-
Electricity	0.726	0.351	PPI – Commercial Electric Power
Fuel Oil, Coal, etc.	0.248	0.108	PPI Refined Petroleum Products
Water and Sewage	0.206	0.197	CPI-U - Water & Sewage Maintenance
Professional Liability Insurance	0.733	1.161	CMS - Professional Liability Premium Index
All Other Products and Services	27.117	19.265	-
All Other Prod. Products	17.914	13.323	-
Pharmaceuticals	6.318	5.103	PPI Prescription Drugs
Food: Direct Purchase	1.122	0.873	PPI Processed Foods & Feeds
Food: Contract Service	1.043	0.620	CPI-U Food Away From Home

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	Proposed FY 2002-based RPL Market Basket	Proposed FY 2002 RPL Market Basket Price Proxies
Chemicals	2.133	1.100	PPI Industrial Chemicals
Blood and Blood Products**	0.748	--	
Medical Instruments	1.795	1.014	PPI Medical Instruments & Equipment
Photographic Supplies	0.167	0.096	PPI Photographic Supplies
Rubber and Plastics	1.366	1.052	PPI Rubber & Plastic Products
Paper Products	1.110	1.000	PPI Converted Paper & Paperboard Products
Apparel	0.478	0.207	PPI Apparel
Machinery and Equipment	0.852	0.297	PPI Machinery & Equipment
Miscellaneous Products	0.783	1.963	PPI Finished Goods less Food and Energy
All Other Services	9.203	5.942	-
Telephone	0.348	0.240	CPI-U – Telephone Services
Postage	0.702	0.682	CPI-U – Postage
All Other: Labor Intensive*	4.453	2.219	ECI - Compensation for Private Service Occupations

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	Proposed FY 2002-based RPL Market Basket	Proposed FY 2002 RPL Market Basket Price Proxies
All Other: Non-Labor Intensive	3.700	2.800	CPI-U All Items
Capital-Related Costs	8.968	10.149	-
Depreciation	5.586	6.186	-
Fixed Assets	3.503	4.250	Boeckh Institutional Construction: 23 year useful life
Movable Equipment	2.083	1.937	WPI – Machinery & Equipment: 11 year useful life
Interest Costs	2.682	2.775	-
Non-profit	2.280	2.081	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)--vintage weighted (23 years)
For-profit	0.402	0.694	Average yield on Moody's Aaa bonds--vintage weighted (23 years)
Other Capital-Related Costs	0.699	1.187	CPI-U – Residential Rent

* Labor-related

** Blood and blood related products is included in miscellaneous products.

NOTE: Due to rounding, weights may not sum to total.

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Below we provide the proxies that we are proposing to use for the FY 2002-based RPL market basket. With the exception of the Professional Liability proxy, all the proposed price proxies for the operating portion of the proposed RPL market basket are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because the PPIs would better reflect the prices faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price change at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer,

we used CPIs only if an appropriate PPI was not available, or if the expenditures were more similar to those of retail consumers in general rather than purchases at the wholesale level. For example, the CPI for food purchased away from home is used as a proxy for contracted food services.

• Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. Appropriately, they are not affected by shifts in employment mix.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Timeliness implies that the proxy is published regularly, at least once a quarter. Availability means that the proxy is publicly available. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs selected by us to be proposed in this regulation meet these criteria.

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

Wages and Salaries

For measuring the price growth of wages in the proposed FY 2002-based RPL market basket, we propose to use the ECI for wages and salaries for civilian hospital workers as the proxy for wages.

Employee Benefits

The proposed FY 2002-based RPL market basket would use the ECI for employee benefits for civilian hospital workers.

Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry would be applied to this category since it includes occupations such as management and consulting, legal, accounting and engineering services.

Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) would be applied to this component.

Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) would be applied to this component.

Water and Sewage

The percentage change in the price of water and sewage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers (CPI Code # CUUR0000SEHG01) would be applied to this component.

Professional Liability Insurance

The proposed FY 2002-based RPL market basket would use the percentage change in the hospital professional liability insurance (PLI) premiums as estimated by the CMS Hospital professional liability index for the proxy of this category. In the FY 1997-based excluded hospital with capital market basket, the same price proxy was used.

We continue to research options for improving our proxy for professional liability insurance. This research includes exploring various options for expanding our current survey, including the identification of another entity that would be willing to work with us to collect more complete and comprehensive data. We are also exploring other options such as third party or industry data that might assist us in creating a more precise measure of PLI premiums. At this time we have not identified a preferred option, therefore, no change is proposed for the proxy in this proposed rule.

Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code # PPI32541DRX) would be used as a proxy for this category. This is a special index produced by BLS and is the same proxy used in the 1997-based excluded hospital with capital market basket.

Food, Direct Purchases

The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) would be applied to this component.

Food, Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEFV) would be applied to this component.

Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) would be applied to this component. While the chemicals hospital's purchase include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, we believe that commodity Code #061 is the appropriate proxy.

Medical Instruments

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) would be applied to this component

Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) would be applied to this component.

Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) would be applied to this component.

Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) would be used.

Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) would be applied to this component.

Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) would be applied to this component.

Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) would be applied to this component. Using this index would remove the double-counting of food and energy prices, which are captured elsewhere in the market basket. The weight for this cost category is higher than in the 1997-based index because the weight for blood and blood products (1.322) is added to it. In the 1997-based excluded hospital with capital market basket we included a separate cost

category for blood and blood products, using the BLS Producer Price Index for blood and derivatives as a price proxy. A review of recent trends in the PPI for blood and derivatives suggests that its movements may not be consistent with the trends in blood costs faced by hospitals. While this proxy did not match exactly with the product hospitals are buying, its trend over time appears to be reflective of the historical price changes of blood purchased by hospitals. However, an apparent divergence in trends in the PPI for blood and derivatives and trends in blood costs faced by hospitals over recent years led us to reevaluate whether the PPI for blood and derivatives was an appropriate measure of the changing price of blood. We ran test market baskets classifying blood in 3 separate cost categories: blood and blood products, contained within chemicals as was done for the 1992-based excluded hospital with capital market basket, and within miscellaneous products. These categories use as proxies the following PPIs: the PPI for blood and blood products, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three proxies, the PPI for finished goods less food and energy moved most like the recent blood cost and price trends. In addition, the impact on the overall market basket by using different proxies for blood was negligible, mostly due to the relatively small weight for blood in the market basket.

Therefore, we are proposing to use the PPI for finished goods less food and energy for the blood proxy because we believe it would best be able to proxy only price changes rather than nonprice factors such as changes in quantities or required tests associated with blood purchased by hospitals. We will continue to evaluate this proxy for its appropriateness and will explore the development of alternative price indexes to proxy the price changes associated with this cost.

Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEED) would be applied to this component.

Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEEC01) would be applied to this component.

Proposed Changes for All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry would be applied to this component.

All Other Services, Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code # CUUR0000SA0) would be applied to this component.

c. Proposed Methodology for Capital Portion of the RPL Market Basket

Unlike for the operating costs of the proposed FY 2002-based RPL market basket, we did not have IRFs, IPFs, and LTCHs FY 2002 Medicare cost report data for the capital cost weights, due to a change in the FY 2002 cost reporting requirements. Rather, we used these hospitals' expenditure data for the capital cost categories of depreciation, interest, and other capital expenses for the most recent year available (FY 2001), and aged the data to a FY 2002 base year using relevant price proxies.

We calculated weights for the RPL market basket capital costs using the same set of Medicare cost reports used to develop the operating share for IRFs, IPFs, and LTCHs. The resulting proposed capital weight for the FY 2002 base year is 10.149 percent. This is based on FY 2001 Medicare cost report data for IRFs, IPFs, and LTCHs, aged to FY 2002 using relevant price proxies.

Lease expenses are not a separate cost category in the market basket, but are distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. We assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead. We base this assignment of 10 percent of lease expenses to overhead on the common assumption that overhead is 10 percent of costs. The remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

Depreciation contains two subcategories: building and fixed equipment and movable equipment. The split between building and fixed equipment and movable equipment was determined using the FY 2001 Medicare cost reports for IRFs, IPFs, and LTCHs. This methodology was also used to compute the 1997-based index (67 FR at 50044).

Total interest expense cost category is split between the government/nonprofit and for-profit hospitals. The 1997-based excluded hospital with capital market basket allocated 85 percent of the total interest cost weight to the government/nonprofit interest, proxied by average yield on domestic municipal bonds, and 15 percent to for-profit interest, proxied by average yield on Moody's Aaa bonds.

We propose to derive the split using the relative FY 2001 Medicare cost report data for IPPS hospitals on interest expenses for the government/nonprofit and for-profit hospitals. Due to insufficient Medicare cost report data for IRFs, IPFs and LTCHs, we propose to use the same split used in the IPPS capital input price index, which is 75–25. We believe it is important that this split reflects the latest relative cost structure of interest expenses for hospitals. Therefore, we propose to use a 75–25 split to allocate interest expenses to government/nonprofit and for-profit. See the Proposed IPPS Rule for FY 2006, Section IV.D, Capital Input Price Index Section.

Since capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital index is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Depreciation and interest expenses are determined by the amount of past and current capital purchases. Therefore, we are proposing to use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the proposed FY 2002-based RPL market basket. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. The capital portion of the proposed FY 2002-based RPL market basket would reflect the annual price changes associated with capital costs, and would be a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual non-vintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes

for Medicare capital-related costs. The capital component of the proposed FY 2002-based RPL market basket would reflect the underlying stability of the capital acquisition process and provide hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare Cost Reports did not have sufficient capital data to meet this need because these data were not required. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. The AHA Panel Survey provided a time series of depreciation expenses through 1997 which could be used to infer capital purchases over time. From 1998 to 2001, total hospital depreciation expenses were calculated by multiplying the AHA Annual Survey total hospital expenses by the ratio of depreciation to total hospital expenses from the Medicare cost reports. Beginning in 2001, the AHA Annual survey began collecting depreciation expenses. We hope to be able to use this data in future rebasings.

In order to estimate capital purchases from AHA data on depreciation and interest expenses, the expected life for each cost category (building and fixed equipment, movable equipment, and debt instruments) is needed. Due to insufficient Medicare cost report data for IRFs, IPFs and LTCHs, we propose to use FY 2001 Medicare cost reports for IPPS hospitals to determine the expected life of building and fixed equipment and movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 2001 Medicare cost reports for IPPS hospitals the expected life of building and fixed equipment was determined to be 23 years, and the expected life of movable equipment was determined to be 11 years.

Although we are proposing to use this methodology for deriving the useful life of an asset, we plan to review it between the publication of the proposed and final rules. We plan to review alternate data sources, if available, and analyze in more detail the hospital's capital cost structure reported in the Medicare cost reports.

We also propose to use the fixed and movable weights derived from FY 2001 Medicare cost reports for IRFs, IPFs and LTCHs to separate the depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. By multiplying the annual depreciation amounts by the expected life calculations from the FY 2001 Medicare cost reports, year-end asset costs for building and fixed equipment and movable equipment could be determined. We then calculated a time series back to 1963 of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series we were able to calculate the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights are explained in detail below.

For proposed building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh Institutional Construction Index. This is the same proxy used for the FY 1997-based excluded hospital with capital market basket. We believe this proxy continues to meet our criteria of reliability, timeliness, availability, and relevance. Since building and fixed equipment has an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods. With real building and fixed equipment purchase estimates available back to 1963, sixteen 23-year periods could be averaged to determine the average vintage weights for building and fixed equipment that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the sixteen 23-year periods. The average of each year across the sixteen 23-year periods is used to determine the 2002 average building and fixed equipment vintage weights.

For proposed movable equipment vintage weights, the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the Producer Price Index for Machinery and Equipment. This is the same proxy used for the FY 1997-based excluded hospital with capital market basket. We believe this proxy, which meets our criteria, is the best measure of price changes for this cost category. Since movable equipment has an expected life of 11 years, the vintage weights for movable equipment are deemed to represent the average purchase pattern of movable equipment over 11-year periods. With real movable equipment purchase estimates available back to 1963, twenty-eight 11-year periods could be averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 11-year period would be calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation is done for each year in the 11-year period, and for each of the twenty-eight 11-year periods. The average of each year across the twenty-eight 11-year periods would be used to determine the FY 2002 average movable equipment vintage weights.

For proposed interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel and Annual Surveys were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Since hospital debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods. With nominal total equipment purchase estimates available back to 1963, sixteen 23-year periods could be averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 23-year period would be calculated by dividing the nominal total capital purchase

amount for any given year by the total amount of purchases in the 23-year period. This calculation would be done for each year in the 23-year period and for each of the sixteen 23-year periods. The average of the sixteen 23-year periods would be used to determine the FY 2002 average interest vintage weights. The vintage weights for the index are presented in Table 8 below.

In addition to the proposed price proxies for depreciation and interest costs described above in the vintage weighted capital section, we propose to use the CPI–U for Residential Rent as a price proxy for other capital-related costs. The price proxies for each of the capital cost categories are the same as those used for the IPPS final rule (67 FR at 50044) capital input price index.

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TABLE 8.—Proposed CMS FY 2002-based RPL Market Basket

Capital Vintage Weights

Year	Fixed Assets (23 year weights)	Movable Assets (11 year weights)	Interest: Capital-related (23 year weights)
1	0.021	0.065	0.010
2	0.022	0.071	0.012
3	0.025	0.077	0.014
4	0.027	0.082	0.016
5	0.029	0.086	0.019
6	0.031	0.091	0.023
7	0.033	0.095	0.026
8	0.035	0.100	0.029
9	0.038	0.106	0.033
10	0.040	0.112	0.036
11	0.042	0.117	0.039
12	0.045		0.043
13	0.047		0.048
14	0.049		0.053
15	0.051		0.056
16	0.053		0.059
17	0.056		0.062
18	0.057		0.064
19	0.058		0.066
20	0.060		0.070
21	0.060		0.071
22	0.061		0.074
23	0.061		0.076
Total	**1.0000**	**1.0000**	**1.0000**

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The proposed FY 2006 update for IRF PPS using the proposed FY 2002-based RPL market basket and Global Insight's 4th quarter 2004 forecast is be 3.1 percent. This includes increases in both the operating section and the capital section. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. Using the current FY 1997-based excluded hospital with capital market basket (66 FR at 41427), Global Insight's fourth quarter 2004

forecast for FY 2006 is also 3.1 percent. Table 4 below compares the proposed FY 2002-based RPL market basket and the FY 1997-based excluded hospital with capital market basket percent changes. For both the historical and forecasted periods between FY 2000 and FY 2008, the difference between the two market baskets is minor with the exception of FY 2002 where the proposed FY 2002-based RPL market basket increased three tenths of a percentage point higher than the FY 1997-based excluded hospital with capital market basket. This is primarily due to the proposed FY 2002-based RPL market basket having a larger compensation (that is, the sum of wages and salaries and benefits) cost weight than the FY 1997-based index and the price changes associated with compensation costs increasing much faster than the prices of other market basket components. Also contributing is the ''all other nonlabor intensive'' cost weight, which is smaller in the proposed FY 2002-based RPL market basket than in the FY 1997-based index, and the slower price changes associated with these costs.

TABLE 9.—PROPOSED FY 2002-BASED RPL MARKET BASKET AND FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET PERCENT CHANGES, FY 2000–FY 2008

Fiscal year (FY)	Proposed rebased FY 2002-based RPL market basket	FY 1997-based excluded hospital market basket with capital
Historical data:		
FY 2000	3.1	3.1
FY 2001	4.0	4.0
FY 2002	3.9	3.6
FY 2003	3.8	3.7
FY 2004	3.6	3.6
Average FYs 2000–2004	3.7	3.6
Forecast:		
FY 2005	3.7	3.8
FY 2006	3.1	3.1
FY 2007	2.9	2.8
FY 2008	2.9	2.8
Average FYs 2005–2008	3.2	3.1

Source: Global Insight, Inc. 4th Qtr 2004, @USMACRO/CNTL1104 @CISSIM/TL1104.SIM

d. Labor-Related Share

Section 1886(j)(6) of the Act specifies that the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

The labor-related share is determined by identifying the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. Using our current definition of labor-related, the labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket. We used the proposed FY 2002-based RPL market basket costs to determine the proposed labor-related share for the IRF PPS. The proposed labor-related share for FY 2006 would be the sum of the proposed FY 2006 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 2006. The sum of the proposed relative importance for FY 2006 for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) would be 71.782 percent, as shown in the chart below. The portion of capital that is influenced by local labor markets would estimated to be 46 percent, which is the same percentage currently used in the IRF prospective payment system. Since the relative importance for capital would be 9.079 percent of the proposed FY 2002-based RPL market basket in FY 2006, we are proposing to take 46 percent of 9.079 percent to determine the proposed capital labor-related share for FY 2006. The result would be 4.176 percent, which we propose to add to 71.782 percent for the operating cost amount to determine the total proposed labor-related share for FY 2006. Thus, the labor-related share that we propose to use for IRF PPS in FY 2006 would be 75.958 percent. This proposed labor-related share is determined using the same methodology as employed in calculating all previous IRF labor-related shares (66 FR at 41357).

Table 10 below shows the proposed FY 2006 relative importance labor-related share using the proposed 2002-based RPL market basket and the FY 1997-based excluded hospital with capital market.

TABLE 10.—PROPOSED TOTAL LABOR-RELATED SHARE

Cost category	Proposed FY 2002-based RPL market basket relative importance (percent) FY 2006	FY 1997 excluded hospital with capital market basket relative importance (percent) FY 2006
Wages and salaries	52.823	48.432
Employee benefits	13.863	11.415
Professional fees	2.907	4.540
All other labor intensive services	2.189	4.496
Subtotal	71.782	68.883
Labor-related share of capital costs	4.176	3.307
Total	75.958	72.190

We are currently continuing an evaluation of our labor-related share methodology used in the IPPS (see 67 FR at 31447 for discussion of our previous analysis). Our evaluation includes regression analysis and reviewing the makeup of cost categories based on our current labor-related definition. A complete discussion of our research is provided in the FY 2006 IPPS proposed rule (See FY 2006 IPPS proposed rule, Section IV, B, 3). The labor-related share used in the IPPS was the first labor-related share used in a prospective payment system. Our methodology for calculating the proposed labor-related share for the IRF PPS is based upon the methodology used in the IPPS.

2. Proposed Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs that are attributable to wages and wage-related costs by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. Not later than October 1, 2001 and at least every 36 months thereafter, the Secretary is required to update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under section 1886(j)(6) of the Act for a FY shall be made in a manner that assures the aggregated payments under section 1886(j)(6) of the Act are not greater or less than those that would have been made in the year without such adjustment.

In our August 1, 2003 final rule, we acknowledged that on June 6, 2003, the Office of Management and Budget (OMB) issued ''OMB Bulletin No.03–04,'' announcing revised definitions of Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the Bulletin may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/b03–04.html.* At that time, we did not propose to apply these new definitions known as the Core-Based Statistical Areas (CBSAs). After further analysis and discussed in detail below, we are proposing to use revised labor market area definitions as a result of the OMB revised definitions to adjust the FY 2006 IRF PPS payment rate. In addition, the IPPS is applying these revised definitions as discussed in the August 11, 2004 final rule (69 FR at 49207).

a. Proposed Revisions of the IRF PPS Geographic Classification

As discussed in the August 7, 2001 final rule, which implemented the IRF PPS (66 FR at 41316), in establishing an adjustment for area wage levels under § 412.624(e)(1), the labor-related portion of an IRF's Federal prospective payment is adjusted by using an appropriate wage index. As set forth in § 412.624(e)(1), an IRF's wage index is determined based on the location of the IRF in an urban or rural area as defined in § 412.602 and further defined in § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii) as urban and rural areas, respectively. An urban area, under the IRF PPS, is defined in § 412.62(f)(1)(ii) as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) as defined by the Office of Management and Budget (OMB). Under § 412.62(f)(1)(iii), a rural area is defined as any area outside of an urban area. In general, an urban area is defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) as defined by the Office of Management and Budget. Under § 412.62(f)(1)(iii), a rural area is defined as any area outside of an urban area. The urban and rural area geographic classifications defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively, were used under the IPPS from FYs 1985 through 2004 (as specified in § 412.63(b)), and have been used under the IRF PPS since it was implemented for cost reporting periods beginning on or after January 1, 2002.

The wage index used for the IRF PPS is calculated by using the acute care IPPS wage index data on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act and without applying the ''rural floor'' under section 4410 of Pub. L. 105–33 (BBA). In addition, Section 4410 of Pub. L. 105–33 (BBA) provides that for the purposes of section 1886(d)(3)(E) of the Act, that the area wage index applicable to hospitals 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 the State. Consistent with past IRF policy, we treat this provision, commonly referred to as the ''rural floor'', as applicable to the acute inpatient hospitals and not IRFs. Therefore, the hospital wage index used for IRFs is commonly referred to as ''pre-floor'' indicating that ''rural floor'' provision is not applied. As a result, the applicable IRF wage index value is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located.

Below, we will provide a description of the current labor markets that have been used for area wage adjustments under the IRF PPS since its implementation of cost reporting periods beginning on or after January 1, 2002. Previously, we have not described the labor market areas used under the IRF PPS in detail, although we have published each area's wage index in tables, in the IRF PPS final rules and

update notices, each year and noted the use of the geographic area in applying the wage index adjustment in IRF PPS payment examples in the final regulation implementing the IRF PPS (69 FR at 41367 through 41368). The IRF industry has also understood that the same labor market areas in use under the IPPS (from the time the IRF PPS was implemented, for cost reporting periods beginning on or after January 1, 2002) would be used under the IRF PPS. The OMB has adopted new statistical area definitions (as discussed in greater detail below) and we are proposing to adopt new labor market area definitions based on these areas under the IRF PPS (as discussed in greater detail below). Therefore, we believe it is helpful to provide a more detailed description of the current IRF PPS labor market areas, in order to better understand the proposed change to the IRF PPS labor market areas presented below in this proposed rule.

The current IRF PPS labor market areas are defined based on the definitions of MSAs, Primary MSAs (PMSAs), and NECMAs issued by the OMB (commonly referred to collectively as ''MSAs''). These MSA definitions, which are discussed in greater detail below, are currently used under the IRF PPS and other prospective payment systems, such as LTCH, IPF, Home Health Agency (HHA), and SNF (Skilled Nursing Facility) PPSs. In the IPPS final rule (67 FR at 49026 through 49034), revised labor market area definitions were adopted under the hospital IPPS (§ 412.64(b)), which were effective October 1, 2004 for acute care hospitals. These new CBSAs standards were announced by the OMB late in 2000.

b. Current IRF PPS Labor Market Areas Based on MSAs

As mentioned earlier, since the implementation of the IRF PPS in the August 7, 2001 IRF PPS final rule, we have used labor market areas to further characterize urban and rural areas as determined under § 412.602 and further defined in § 412.62(f)(1)(ii) and (f)(1)(iii). To this end, we have defined labor market areas under the IRF PPS based on the definitions of MSAs, PMSAs, and NECMAs issued by the OMB, which is consistent with the IPPS approach. The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of 1 million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs (as further discussed in section III.B.2.d.ii of this proposed rule). If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

These different designations use counties as the building blocks upon which they are based. Therefore, IRFs are assigned to either an MSA, PMSA, or NECMA based on whether the county in which the IRF is located is part of that area. All of the counties in a State outside a designated MSA, PMSA, or NECMA are designated as rural. For the purposes of calculating the wage index, we combine all of the counties in a State outside a designated MSA, PMSA, or NECMA together to calculate the statewide rural wage index for each State.

c. Core-Based Statistical Areas (CBSAs)

OMB reviews its Metropolitan Area definitions preceding each decennial census. As discussed in the IPPS final rule (69 FR at 49027), in the fall of 1998, OMB chartered the Metropolitan Area Standards Review Committee to examine the Metropolitan Area standards and develop recommendations for possible changes to those standards. Three notices related to the review of the standards, providing an opportunity for public comment on the recommendations of the Committee, were published in the **Federal Register** on the following dates: December 21, 1998 (63 FR at 70526); October 20, 1999 (64 FR at 56628); and August 22, 2000 (65 FR at 51060).

In the December 27, 2000 **Federal Register** (65 FR at 82228 through 82238), OMB announced its new standards. In that notice, OMB defines CBSA, beginning in 2003, as ''a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.'' The standards designate and define two categories of CBSAs: MSAs and Micropolitan Statistical Areas (65 FR at 82235 through 82238).

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters of at least 10,000 population, but less than 50,000 population. Counties that do not fall within CBSAs (either MSAs or Micropolitan Areas) are deemed ''Outside CBSAs.'' In the past, OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were ''Outside MSAs.'' On June 6, 2003, OMB announced the new CBSAs, comprised of MSAs and the new Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04–03.html.*)

The new CBSA designations recognize 49 new MSAs and 565 new Micropolitan Areas, and revise the composition of many of the existing MSAs. There are 1,090 counties in MSAs under the new CBSA designations (previously, there were 848 counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were prior to the change in designations, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer designated to either an MSA or a new Micropolitan Area: Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA. For a more detailed discussion of the conceptual basis of the new CBSAs, refer to the IPPS final rule (67 FR at 49026 through 49034).

d. Proposed Revisions to the IRF PPS Labor Market Areas

In its June 6, 2003 announcement, OMB cautioned that these new definitions ''should not be used to develop and implement Federal, State, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas.''

We currently use MSAs to define labor market areas for purposes of the wage index. In fact, MSAs are also used to define labor market areas for purposes of the wage index for many of the other Medicare prospective payment systems (for example, LTCH, SNF, HHA, IPF, and Outpatient). While we recognize MSAs are not designed specifically to define labor market areas, we believe they represent a reasonable and appropriate proxy for this purpose, because they are based upon characteristics we believe also generally reflect the characteristics of unified labor market areas. For example, CBSAs reflect a core population plus an adjacent territory that reflects a high degree of social and economic integration. This integration is measured by commuting ties, thus demonstrating that these areas may draw workers from

the same general areas. In addition, the most recent CBSAs reflect the most up to date information. The OMB reviews its MA definitions preceding each decennial census to reflect recent population changes and the CBSAs are based on the Census 2000 data. Our analysis and discussion here are focused on issues related to adopting the new CBSA designations to define labor market areas for the purposes of the IRF PPS.

Historically, Medicare PPSs have utilized Metropolitan Area (MA) definitions developed by OMB. The labor market areas currently used under the IRF PPS are based on the MA definitions issued by OMB. OMB reviews its MA definitions preceding each decennial census to reflect more recent population changes. Thus, the CBSAs are OMB's latest MA definitions based on the Census 2000 data. Because we believe that the OMB's latest MA designations more accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, we are proposing to adopt the revised labor market area designations based on the OMB's CBSA designations.

As specified in § 412.624(e)(1), we explained in the August 7, 2001 final rule that the IRF PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Since OMB's CBSA designations are based on Census 2000 data and reflect the most recent available geographic classifications, we are proposing to revise the labor market area definitions used under the IRF PPS. Specifically, we are proposing to revise the IRF PPS labor market definitions based on the OMB's new CBSA designations effective for IRF PPS discharges occurring on or after October 1, 2005. Accordingly, we are proposing to revise § 412.602 to specify that for discharges occurring on or after October 1, 2005, the application of the wage index under the IRF PPS would be made on the basis of the location of the facility in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). (As a conforming change, we are also proposing to revise § 412.602, definitions for rural and urban areas effective for discharges occurring on or after October 1, 2005 would be defined in § 412.64(b)(1)(ii)(A) through (C). To further clarify, we will revise the regulation text to explicitly reference urban and rural definitions for a cost-reporting period beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005 under § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii)).

We note that these are the same labor market area definitions (based on the OMB's new CBSA designations) implemented under the IPPS at § 412.64(b), which were effective for those hospitals beginning October 1, 2004 as discussed in the IPPS final rule (69 FR at 49026 through 49034). The similarity between the IPPS and the IRF PPS includes the adoption in the initial implementation of the IRF PPS of the same labor market area definitions under the IRF PPS that existed under the IPPS at that time, as well as the use of acute care hospitals' wage data in calculating the IRF PPS wage index. In addition, the OMB's CBSA-based designations reflect the most recent available geographic classifications and more accurately reflects current labor markets. Therefore, we believe that proposing to revise the IRF PPS labor market area definitions based on OMB's CBSA-based designations are consistent with our historical practice of modeling IRF PPS policy after IPPS policy.

Below, we discuss the composition of the proposed IRF PPS labor market areas based on the OMB's new CBSA designations.

i. New England MSAs

As stated above, in the August 7, 2001 final rule, we currently use NECMAs to define labor market areas in New England, because these are county-based designations rather than the 1990 MSA definitions for New England, which used minor civil divisions such as cities and towns. Under the current MSA definitions, NECMAs provided more consistency in labor market definitions for New England compared with the rest of the country, where MSAs are county-based. Under the new CBSAs, OMB has now defined the MSAs and Micropolitan Areas in New England on the basis of counties. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs.

In order to create consistency among all labor market areas and to maintain these areas on the basis of counties, we are proposing to use the county-based areas for all MSAs in the nation, including those in New England. Census has now defined the New England area based on counties, creating a city- and town-based system as an alternative. We believe that adopting county-based labor market areas for the entire country except those in New England would lead to inconsistencies in our designations. Adopting county-based labor market areas for the entire country provides consistency and stability in Medicare program payment because all of the labor market areas throughout the country, including New England, would be defined using the same system (that is, counties) rather than different systems in different areas of the country, and minimizes programmatic complexity.

In addition, we have consistently employed a county-based system for New England for precisely that reason: to maintain consistency with the labor market area definitions used throughout the country. Because we have never used cities and towns for defining IRF labor market areas, employing a county-based system in New England maintains that consistent practice. We note that this is consistent with the implementation of the CBSA-based designations under the IPPS for New England (see 69 FR at 49028). Accordingly, in this proposed rule, we are proposing to use the New England MSAs as determined under the proposed new CBSA-based labor market area definitions in defining the proposed revised IRF PPS labor market areas.

ii. Metropolitan Divisions

Under OMB's new CBSA designations, a Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties. A county qualifies as a main county if 65 percent or more of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75. A county qualifies as a secondary county if 50 percent or more, but less than 65 percent, of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75. After all the main and secondary counties are identified and grouped, each additional county that already has qualified for inclusion in the MSA falls within the Metropolitan Division associated with the main/secondary county or counties with which the county at issue has the highest employment interchange measure. Counties in a Metropolitan Division must be contiguous (65 FR at 82236).

The construct of relatively large MSAs being comprised of Metropolitan Divisions is similar to the current construct of the CMSAs comprised of PMSAs. As noted above, in the past, OMB designated CMSAs as

Metropolitan Areas with a population of 1 million or more and comprised of two or more PMSAs. Under the IRF PPS, we currently use the PMSAs rather than CMSAs to define labor market areas because they comprise a smaller geographic area with potentially varying labor costs due to different local economies. We believe that CMSAs may be too large of an area with a relatively large number of hospitals, to accurately reflect the local labor costs of all the individual hospitals included in that relatively ''large'' area. A large market area designation increased the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals within the market area designation. Similarly, we believe that MSAs with a population of 2.5 million or greater may be too large of an area to accurately reflect the local labor costs of all the individual hospitals included in that relatively ''large'' area. Furthermore, as indicated above, Metropolitan Divisions represent the closest approximation to PMSAs, the building block of the current IRF PPS labor market area definitions, and therefore, would most accurately maintain our current structuring of the IRF PPS labor market areas. Therefore, as implemented under the IPPS (69 FR at 49029), we are proposing to use the Metropolitan Divisions where applicable (as describe below) under the proposed new CBSA-based labor market area definitions.

In addition to being comparable to the organization of the labor market areas under the current MSA designations (that is, the use of PMSAs rather than CMSAs), we believe that proposing to use Metropolitan Divisions where applicable (as described below) under the IRF PPS would result in a more accurate adjustment for the variation in local labor market areas for IRFs. Specifically, if we would recognize the relatively ''larger'' CBSA that comprises two or more Metropolitan Divisions as an independent labor market area for purposes of the wage index, it would be too large and would include the data from too many hospitals to compute a wage index that would accurately reflect the various local labor costs of all the individual hospitals included in that relatively ''large'' CBSA. As mentioned earlier, a large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals within the market area designation. Rather, by proposing to recognize Metropolitan Divisions where applicable (as described below) under the proposed new CBSA-based labor market area definitions under the IRF PPS, we believe that in addition to more accurately maintaining the current structuring of the IRF PPS labor market areas, the local labor costs would be more accurately reflected, thereby resulting in a wage index adjustment that better reflects the variation in the local labor costs of the local economies of the IRFs located in these relatively ''smaller'' areas.

Below we describe where Metropolitan Divisions would be applicable under the proposed new CBSA-based labor market area definitions under the IRF PPS.

Under the OMB's CBSA-based designations, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, DC. Although these MSAs were also CMSAs under the prior definitions, in some cases their areas have been altered. Under the current IRF PPS MSA designations, Boston is a single NECMA. Under the proposed CBSA-based labor market area designations, it would be comprised of four Metropolitan Divisions. Los Angeles would go from four PMSAs under the current IRF PPS MSA designations to two Metropolitan Divisions under the proposed CBSA-based labor market area designations. The New York CMSA would go from 15 PMSAs under the current IRF PPS MSA designations to only four Metropolitan Divisions under the proposed CBSA-based labor market area designations. The five PMSAs in Connecticut under the current IRF PPS MSA designations would become separate MSAs under the proposed CBSA-based labor market area designations because two MSAs became separate MSAs. The number of PMSAs in New Jersey, under the current IRF PPS MSA designations would go from five to two, with the consolidation of two New Jersey PMSAs (Bergen-Passaic and Jersey City) into the New York-Wayne-White Plains, NY-NJ Division, under the proposed CBSA-based labor market area designations. In San Francisco, under the proposed CBSA-based labor market area designations there are only two Metropolitan Divisions. Currently, there are six PMSAs, some of which are now separate MSAs under the current IRF PPS labor market area designations.

Under the current IRF PPS labor market area designations, Cincinnati, Cleveland, Denver, Houston, Milwaukee, Portland, Sacramento, and San Juan are all designated as CMSAs, but would no longer be designated as CMSAs under the proposed CBSA-based labor market area designations. As noted previously, the population threshold to be designated a CMSA under the current IRF PPS labor market area designations is 1 million. In most of these cases, counties currently in a PMSA would become separate, independent MSAs under the proposed CBSA-based labor market area designations, leaving only the MSA for the core area under the proposed CBSA-based labor market area designations.

iii. Micropolitan Areas

Under the new OMB's CBSA-based designations, Micropolitan Areas are essentially a third area definition consisting primarily of areas that are currently rural, but also include some or all of areas that are currently designated as urban MSA. As discussed in greater detail in the IPPS final rule (69 FR at 49029 through 49032), how these areas are treated would have significant impacts on the calculation and application of the wage index. Specifically, whether or not Micropolitan Areas are included as part of the respective statewide rural wage indices would impact the value of the statewide rural wage index of any State that contains a Micropolitan Area because a hospital's classification as urban or rural affects which hospitals' wage data are included in the statewide rural wage index. As discussed above in section III.B.2.b of this proposed rule, we combine all of the counties in a State outside a designated urban area to calculate the statewide rural wage index for each State.

Including Micropolitan Areas as part of the statewide rural labor market area would result in an increase to the statewide rural wage index because hospitals located in those Micropolitan Areas typically have higher labor costs than other rural hospitals in the State. Alternatively, if Micropolitan Areas were to be recognized as independent labor market areas, because there would be so few hospitals in those areas to complete a wage index, the wage indices for IRFs in those areas could become relatively unstable as they might change considerably from year to year.

We currently use MSAs to define urban labor market areas and group all the hospitals in counties within each

State that are not assigned to an MSA into a statewide rural labor market area. Therefore, we used the terms ''urban'' and ''rural'' wage indices in the past for ease of reference. However, the introduction of Micropolitan Areas by the OMB potentially complicates this terminology because these areas include many hospitals that are currently included in the statewide rural labor market areas.

We are proposing to treat Micropolitan Areas as rural labor market areas under the IRF PPS for the reasons outlined below. That is, counties that are assigned to a Micropolitan Area under the CBSA-based designations would be treated the same as other ''rural'' counties that are not assigned to either an MSA or a Micropolitan Area. Therefore, in determining an IRF's applicable wage index (based on IPPS hospital wage index data) we are proposing that an IRF in a Micropolitan Area under OMB's CBSA designations would be classified as ''rural'' and would be assigned the statewide rural wage index for the State in which it resides.

In the IPPS final rule (69 FR at 49029 through 49032), we discuss our evaluation of the impact of treating Micropolitan areas as part of the statewide rural labor market area instead of treating Micropolitan Areas as independent labor market areas for hospitals paid under the IPPS. As an alternative to treating Micropolitan Areas as part of the statewide rural labor market area for purposes of the IRF PPS, we examined treating Micropolitan Areas as separate (urban) labor market areas, just as we did when implementing the revised labor market areas under the IPPS. As discussed in greater detail in that same final rule, the designation of Micropolitan Areas as separate urban areas for wage index purposes would have a dramatic impact on the calculation of the wage index. This is because Micropolitan areas encompass smaller populations than MSAs, and tend to include fewer hospitals per Micropolitan area. Currently, there are only 25 MSAs with one hospital in the MSA. However, under the new proposed CBSA-based definitions, there are 373 Micropolitan Areas with one hospital, and 49 MSAs with only one hospital.

Since Micropolitan Areas encompass smaller populations than MSAs, they tend to include fewer hospitals per Micropolitan Area, recognizing Micropolitan Areas as independent labor market areas would generally increase the potential for dramatic shifts in those areas' wage indices from one year to the next because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of the area. The large number of labor market areas with only one hospital and the increased potential for dramatic shifts in the wage indexes from one year to the next is a problem for several reasons. First, it creates instability in the wage index from year to year for a large number of hospitals. Second, it reduces the averaging effect (this averaging effect allows for more data points to be used to calculate the representative standard of measured labor costs within a market area) lessening some of the incentive for hospitals to operate efficiently. This incentive is inherent in a system based on the average hourly wages for a large number of hospitals, as hospitals could profit more by operating below that average. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. Third, it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals. Therefore, in order to minimize the potential instability in payment levels from year to year, we believe it would be appropriate to treat Micropolitan Areas as part of the statewide rural labor market area under the IRF PPS.

For the reasons noted above, and consistent with the treatment of these areas under the IPPS, we are proposing not to adopt Micropolitan Areas as independent labor market areas under the IRF PPS. Under the proposed new CBSA-based labor market area definitions, we are proposing that Micropolitan Areas be considered a part of the statewide rural labor market area. Accordingly, we are proposing that the IRF PPS statewide rural wage index be determined using the acute-care IPPS hospital wage data (the rational for using IPPS hospital wage data is discussed in section III.B.2.f of this proposed rule) from hospitals located in non-MSA areas and that the statewide rural wage index be assigned to IRFs located in those areas.

e. Implementation of the Proposed Changes To Revise the Labor Market Areas

Under section 1886(j) of the Act, as added by section 4421 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) and as amended by section 125 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) and section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), which requires the implementation of such prospective payment system, the Secretary generally has broad authority in developing the IRF PPS, including whether and how to make adjustments to the IRF PPS.

To facilitate an understanding of the proposed policies related to the proposed change to the IRF PPS labor market areas discussed above, in Table 3 of the Addendum of this proposed rule, we are providing a listing of each IRF's state and county location; existing MSA labor market area designation; and its proposed new CBSA designation based on county information from our online survey, certification, and reporting (OSCAR) database, and an Iowa Foundation for Medical Care (IFMC) report listing providers and their state and county location that submitted IRF–PAIs during the past 18 months (report request made in February 2005). We encourage IRFs to review the county location and both the current and proposed labor market area assignments for accuracy. Any questions or corrections (including additions or deletions) to the information provided in Table 3 of the Addendum should be emailed to the following CMS Web address: *IRFPPSInfo@cms.hhs.gov.* A link to this address can be found on the following CMS Web page *http://www.cms.hhs.gov/providers/irfpps/*.

When the revised labor market areas based on OMB's new CBSA-based designations were adopted under the IPPS beginning on October 1, 2004, a transition to the new designations was established due to the scope and substantial implications of these new boundaries and to buffer the subsequent substantial impacts on numerous hospitals. As discussed in the IPPS final rule (69 FR at 49032), during FY 2005, a blend of wage indices is calculated for those acute care IPPS hospitals experiencing a drop in their wage indices because of the adoption of the new labor market areas. The most substantial decrease in wage index impacts urban acute-care hospitals that were designated as rural under the CBSA-based designations.

While we recognize that, just like IPPS hospitals, IRFs may experience decreases in their wage index as a result of the proposed labor market area changes, our data analysis showed that a majority of IRFs either expect no change in wage index or an increase in wage index based on CBSA definitions.

In addition, a very small number of IRFs (3 percent) would experience a decline of 5 percent or more in the wage index based on CBSA designations. A 5 percent decrease in the wage index for an IRF may result in a noticeable decrease in their wage index compared to what their wage index would have been for FY 2006 under the MSA-based designations. We also found that a very small number of IRFs (4 percent) would experience a change in either rural or urban designation under the CBSA-based definitions. Since a majority of IRFs would not be significantly impacted by the proposed labor market areas, we believe it is not necessary to propose a transition to the proposed new CBSA-based labor market area for the purposes of the IRF PPS wage index. The main purpose of a transition is to buffer hospitals that would be significantly impacted by a proposed policy. Since the impact of the proposed labor market areas upon IRFs would be minimal, the need to transition is absent. We recognize that there would be many alternatives to efficiently implement the proposed CBSA-based geographic designations. The statute confers broad authority to the Secretary under 1886(j)(6) of the Act to establish factor for area wage differences by a factor such that budget neutral wage index options may be considered. Thus, we considered three budget neutral alternatives that could implement the adoption of the proposed CBSA-based designations as discussed below. Even though a majority of IRFs would not be significantly impacted by the proposed labor market areas, we wanted to be diligent and at least examine transition policies and the affect on the system. We needed to conduct the analysis to determine how IRFs fare under such a proposed policy.

One alternative we considered institutes a one-year transition with a blended wage index, equal to 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both based on the FY 2001 hospital wage data), for all providers. In this scenario, a blended wage index of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index was used because in the IPPS final rule (69 FR at 49033) a blended wage index employed 50 percent of the FY 2001 hospital wage index data and the old labor market definitions, and 50 percent of the wage index employing FY 2001 wage index data and the new labor market definitions. However, we found that while this would help some IRFs that are adversely affected by the changes to the MSAs, it would also reduce the wage index values (compared to fully adopting the CBSA wage index value) for IRFs that would be positively affected by the changes. Thus, the unadjusted payment rate for all providers would be slightly reduced. Therefore, a majority of the IRFs would not benefit if all providers are given a blended wage index in a budget neutral manner (such that estimated aggregate, overall payments to IRFs would not change under the proposed labor market area definitions).

A second alternative we considered consists of a one-year transition with a blended wage index, equal to 50 percent of the FY 2006 MSA wage index and 50 percent of the FY 2006 CBSA-based wage index (both based on the FY 2001 hospital wage data), only for providers that would experience a decrease due solely to the changes in the labor market definitions. In this second alternative, a blended wage index of 50 percent of the FY 2006 MSA wage index and 50 percent of the FY 2006 CBSA-based wage index was determined because in the IPPS final rule (69 FR at 49033) a blended wage index employed 50 percent of the FY 2001 hospital wage index data and the old labor market definitions, and 50 percent of the wage index employing FY 2001 wage index data and the new labor market definitions. Therefore, providers that would experience a decrease in their FY 2006 wage index under the CBSA-based definitions compared to the wage index they would have received under the MSA-based definitions (in both cases using FY 2001 hospital wage data) would receive a blended wage index as described above.

When we performed our analysis, we found that the unadjusted payment amounts decreased substantially more under this option than they did either by using the first option discussed above or by fully adopting the CBSA-based designations. As with the first alternative, the positive impact of blending in order decrease the impacts for a relatively small number of IRFs would require reduced payment rates for all providers, including the IRFs receiving a blended wage index.

As discussed in the August 11, 2004 IPPS final rule (69 FR at 49032), during FY 2005, a hold harmless policy was implemented to minimize the overall impact of hospitals that were in FY 2004 designated as urban under the MSA designations, but would become rural under the CBSA designations. In the same final rule, hospitals were afforded a three-year hold harmless policy because the IPPS determined that acute-care hospitals that changed designations from urban to rural would be substantially impacted by the significant change in wage index. Although we considered a hold harmless policy for IRFs that would be substantially impacted from the change in wage index due to the CBSA-based designation, we found that an extremely small number of IRFs (4.4 percent) would change designations. In addition, currently urban facilities that become rural under the CBSA-based definitions would receive the rural facility adjustment, which we are proposing to increase from 19.14 percent to 24.1 percent (discussed in further detail in section III.B.4 of this proposed rule). Thus, the impact on urban facilities that become rural would be mitigated by the rural adjustment.

We also found that 91 percent of rural facilities that would be designated as urban under the CBSA-based definitions would experience an increase in the wage index. Furthermore, a majority (74 percent) of rural facilities that become urban would experience at least a 5 percent to 10 percent or more increase in wage index. Thus, we do not believe it is appropriate or necessary to adopt a hold harmless policy for facilities that would experience a change in designation under the CBSA-based definitions.

Finally, we note that section 505 of the MMA established new section 1886(d)(13) of the Act. The new section 1886(d)(13) requires that the Secretary establish a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. We believe that this requirement for an ''out-commuting'' or ''out-migration'' adjustment applies specifically to the IPPS. Therefore, we will not be proposing such an adjustment for the IRF PPS.

We are not proposing a transition, a hold harmless policy, nor an ''out-commuting'' adjustment under the IRF PPS from the current MSA-based labor market areas designations to the new CBSA-based labor market area designations as discussed below. We are proposing to adopt the new CBSA-based labor market area definitions beginning with the 2006 IRF PPS fiscal year without a transition period, without a hold harmless policy, and without an ''out-commuting'' adjustment. We believe that this proposed policy is appropriate because despite significant similarities between the IRF PPS and the IPPS, there are clear distinctions between the payment systems, particularly regarding wage index issues.

The most significant distinction upon which we have based this proposed

policy determination is that where acute care hospitals have been paid using full wage index adjusted payments since 1983 and have used the previous IPPS MSA-based labor market area designations for over 10 years, under the IRF PPS we have been using the excluded pre-reclassification and pre-floor MSA-based wage index for cost reporting periods beginning on or after January 1, 2002. Since the implementation of the IRF PPS has only used the MSA-based labor market area designations since 2002 of which the first year was a transition year, many IRFs received a blended payment that consisted of a percentage of TEFRA and a percentage of the IRF PPS rate (as described below). Since many IRFs were initially under the transition period whereby many IRFs received a blend of TEFRA payments and the adjusted Federal prospective payment rates in accordance with section 1886(j)(1) of the Act and as specified in § 412.626, IRFs may still be adjusting to the changes in wage index and thus has not established a long history of an expected wage index from year to year. We may reasonably expect that IRFs would not experience a substantial impact on their respective wage indices because under a relatively new IRF PPS, IRFs are adjusting to the change of being paid a Federal prospective payment rate. Our data analysis also shows that a minimal number of IRFs would experience a decrease of more than 5 percent in the wage index. A 5 percent decrease in the wage index for an IRF would possibly result in a noticeable decrease in their wage index compared to what their wage index would have been for FY 2006 under the MSA-based designations. In addition, under the CBSA designation, a small number of IRFs would experience a change from their current urban or rural designation. Therefore, the overall impact of IRFs under the MSA-based designations versus the CBSA-based designations did not result in a dramatic change overall.

Although the wage index has been a stable feature of the acute care hospital IPPS since its 1983 implementation and has utilized the prior MSA-based labor market area designation for over 10 years, this is not the case for the IRF PPS which has only been implemented for cost reporting periods beginning on or after January 1, 2002. Therefore, if the proposed CBSA-based labor market area designations were adopted they would have a negligible impact on IRFs because the adoption of the CBSA-based designations are proposed in a budget neutral manner (as discussed in detail in section IV of this proposed rule).

The impact of adopting the proposed CBSA-based wage index has shown in our impact analysis to have very little impact on the overall payment rates to the extent the proposed refinements to the overall system are also implemented (as discussed below). In addition, unlike other post-acute care payment systems, the IRF PPS payments apply a rural facility adjustment to account for higher costs in rural facilities (as discussed in 66 FR at 41359). We are proposing to increase the current rural adjustment from 19.14 percent to 24.1 percent (as discussed in section III.4 of this proposed rule). Therefore, IRFs that are designated as urban under the MSA-based definitions, but that would be classified as rural under the proposed CBSA-based definitions, will receive a facility add-on of 24.1 percent.

In sum, the IRF PPS has only been implemented for hospital cost reporting periods beginning on or after January 1, 2002 (which means that payment to IRFs have only been governed by the IRF PPS for slightly more than 3 years). In addition, a small number of IRFs would experience a change in rural or urban designations under the CBSA-based designations. To the extent the proposed changes in this rule are adopted, the change in labor market area for an urban facility to a rural facility is expected to be offset by the rural adjustment we are proposing to increase from 19.14 to 24.1 percent as discussed below. We also found that a majority of IRFs would experience no change in wage index or an increase. Thus, we are proposing to fully adopt the CBSA-based designations without a hold harmless policy. We believe that it is not appropriate or necessary to propose a transition to the proposed new CBSA-based labor market area for the purpose of the IRF PPS wage index adjustment as specified under § 412.624 as explained previously in this section. In addition, as explained above, we believe there are not sufficient data to support a transition from MSA-based designations to the proposed CBSA-based designations.

f. Wage Index Data

In the August 7, 2001 final rule, we established an IRF wage index based on FY 1997 acute care hospital wage data to adjust the FY 2002 IRF payment rates. For the FY 2003 IRF PPS payment rates, we applied the same wage adjustment as used for FY 2002 IRF PPS rates because we determined that the application of the wage index and labor-related share used in FY 2002 provided an appropriate adjustment to account for geographic variation in wage levels that was consistent with the statute. For the FY 2004 IRF PPS payment rates, we used the hospital wage index based on FY 1999 acute care hospital wage data. For the FY 2005 IRF PPS payment rates, we used the hospital wage index based on FY 2000 acute care hospital wage data. We are proposing to use FY 2001 acute care hospital wage data for FY 2006 IRF PPS payment rates because it is the most recent final data available. We believe that a wage index based on acute care hospital wage data is the best proxy and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets. Since acute care hospitals compete in the same labor market areas as IRFs, the wage data of acute care hospitals should accurately capture the relationship of wages and wage-related costs of IRF in an area as comparable to the national average. In the August 1, 2001 final rule (66 FR at 41358) we established FY 2002 IRF PPS wage index values for the 2002 IRF PPS fiscal year calculated from the same data used to compute the FY 2001 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act and without applying the ''rural floor'' under section 4410 of Pub. L. 105–33 (BBA) (as discussed in section III.B.2.a of this proposed rule). Acute care hospital inpatient wage index data is also used to establish the wage index adjustment used in other PPSs (for example, LTCH, IPF, HHA, and SNF). As we discussed in the August 7, 2001 final rule (66 FR at 41316, 41358), since hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of this IRF data it is not appropriate at this time to propose a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages or if a geographic reclassification adjustment under the IRF PPS is appropriate. However, we believe that a wage index based on acute care hospital data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets. Also, we propose to continue to use the same method for calculating wage indices as was indicated in the August 7, 2001 final rule (69 FR at 41357 through 41358). In addition, 1886(d)(8) and

1886(d)(10) of the Act which permits reclassification is applicable only to inpatient acute care hospitals at this time. The wage adjustment established under the IRF PPS is based on an IRF's actual location without regard to the urban or rural designation of any related or affiliated provider.

In proposing to adopt the CBSA-based designations, we recognize that there may be geographic areas where there are no hospitals, and thus no hospital wage data on which to base the calculation of the IRF PPS wage index. We found that this occurred in two States—Massachusetts and Puerto Rico—where, using the CBSA-based designations, there were no hospitals located in rural areas. At present, no IRFs are affected by this lack of data, because currently there are no rural IRFs in these two States. If, rural IRFs open in these two States, we propose, for FY 2006, to use the rural FY 2001 MSA-based hospital wage data for that State to determine the wage index of such IRFs. In other words, we would use the same wage data (the FY 2001 hospital wage data) used to calculate the FY 2006 IRF wage index. However, rather than using CBSA-based designations, we would use MSA-based designations to determine the rural wage index of the State. Using such MSA-based designations there would be rural wage indices for both Massachusetts and Puerto Rico. We believe this is the most reasonable approach, as we would be using the same hospital wage data used to calculate the CBSA-based wage indices.

In the event this occurs in urban areas where IRFs are located, we are proposing to use the average of the urban hospital wage data throughout the State as a reasonable proxy for the urban areas without hospital wage data. Therefore, urban IRFs located in geographic areas without any hospital wage data would receive a wage index based on the average wage index for all urban areas within the State. This does not presently affect any urban IRFs for FY 2006 because there are no IRFs located in urban areas without hospital wage data. However, the policy would apply to future years when there may be urban IRFs located in geographic areas with no corresponding hospital wage data.

We believe this policy is reasonable because it maintains a CBSA-based wage index system, while creating an urban proxy for IRFs located in urban areas without corresponding hospital wage data. We note that we could not apply a similar averaging in rural areas, because in the rural areas there is no State rural hospital wage data available for averaging on a State-wide basis. For example, in Massachusetts and Puerto Rico, using a CBSA-based designation system, there are simply no rural hospitals in the State upon which we could base an average.

In addition, we note that the Secretary has broad authority under 1886(j)(6) to update the wage index on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Therefore, for FY 2006 we propose to use FY 2001 MSA-based hospital wage data for rural Massachusetts and rural Puerto Rico in the event there are rural IRFs in such States. In addition, for FY 2006 and thereafter, we propose to calculate a statewide urban average in the event that there exist urban IRFs in geographic areas with no corresponding hospital wage data. We solicit comments on these approaches to calculate the wage index values for areas without hospital wage data for this and subsequent fiscal years. We note that for fiscal years 2007 and thereafter, we likely will not calculate the MSA-based rural area indices, as the acute care hospital IPPS will no longer publish MSA-based wage tables. Thus, we specifically request comments on the approach to be used for IRFs in rural areas without corresponding hospital wage data for fiscal years 2007 and thereafter.

For the reasons discussed above, we are proposing to continue the use of the acute care hospital inpatient wage index data generated from cost reporting periods beginning during FY 2001 without taking into account geographic reclassification as specified under sections 1886(d)(8) and (d)(10) of the Act and without applying the ''rural floor'' under section 4410 of Pub. L. 105–33 (BBA) (as discussed in section III.B.2.a of this proposed rule). We believe that cost reporting period FY 2001 would be used to determine the applicable wage index values under the IRF PPS because these are the best available data. These data are the same FY 2001 acute care hospital inpatient wage data that were used to compute the FY 2005 wage indices. The proposed full wage index values that would be applicable for IRF PPS discharges occurring on or after October 1, 2005 are shown in Addendum 1, Tables 2a (for urban areas) and 2b (for rural areas) in the Addendum of this proposed rule.

In addition, any proposed adjustment or update to the IRF wage index made as specified under section 1886(j)(6) of the Act would be made in a budget neutral manner that assures that the estimated aggregated payments under this subsection in the FY year are not greater or less than those that would have been made in the year without such adjustment. Therefore, we are proposing to calculate a budget-neutral wage adjustment factor as established in the July 30, 2004 notice and as specified in § 412.624(e)(1). We will continue to use the following steps to ensure that the proposed FY 2006 IRF standard payment conversion factor reflects the update to the proposed CBSA wage indices and to the proposed labor-related share in a budget neutral manner:

Step 1: Determine the total amount of the estimated FY 2005 IRF PPS rates using the FY 2005 standard payment conversion factor and the labor-related share and the wage indices from FY 2005 (as published in the July 30, 2004 final notice).

Step 2: Calculate the total amount of estimated IRF PPS payments using the FY 2005 standard payment conversion factor and the proposed updated CBSA-based FY 2006 labor-related share and wage indices described above.

Step 3: Divide the amount calculated in step 1 by the amount calculated in step 2, which equals the proposed FY 2006 budget-neutral wage adjustment factor of 0.9996.

Step 4: Apply the proposed FY 2006 budget-neutral wage adjustment factor from step 3 to the FY 2005 IRF PPS standard payment conversion factor after the application of the market basket update, described above, to determine the proposed FY 2006 standard payment conversion factor.

3. Proposed Teaching Status Adjustment

Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the prospective payment rates for the IRF PPS by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under this authority, in the August 7, 2001 final rule (66 FR 41316, 41359), we considered implementing an adjustment for IRFs that are, or are part of, teaching institutions. However, because the results of our regression analysis, using FY 1999 data, showed that the indirect teaching cost variable was not significant, we did not implement a payment adjustment for indirect teaching costs in that final rule. The regression analysis conducted by RAND for this proposed rule, using FY 2003 data, shows that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs. Therefore, we are proposing to establish a facility level adjustment to the Federal per discharge base rate for IRFs that are, or are part of,

teaching institutions for the reasons discussed below (the ''teaching status adjustment''). However, as discussed below, we have some concerns about proposing a teaching status adjustment. The policy implications of implementing a teaching status adjustment on the basis of the results of RAND's recent analysis oblige us to seek assurance that these results do not reflect an aberration based on only a single year's data and that the teaching status adjustment can be implemented in such a way that it would be equitable to all IRFs. Analysis of future data (FY 2004 or later) would give us such assurance because it would allow the effects of the other proposed changes outlined in this proposed rule to be realized and allow us to determine whether the significant coefficient on the teaching variable continues to be present in the future data.

The purpose of the proposed teaching status adjustment would be to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education programs.

We are proposing to implement the proposed teaching status adjustment in a budget neutral manner (that is, keeping aggregate payments for FY 2006 with the proposed teaching adjustment the same as aggregate payments for FY 2006 without the proposed teaching adjustment) for the reasons discussed below. (As a conforming change, we are proposing to revise § 412.624 to add a new section (e)(4) as the teaching status adjustment. Specifically, § 412.624(e)(4) would be for discharges on or after October 1, 2005. We propose to adjust the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions. This adjustment would be made on a claim basis as an interim payment and the final payment in full for the claim would be made during the final settlement of the cost report. Thus, we would redesignate the current (e)(4) and (e)(5) as (e)(5) and (e)(6)).

Medicare makes direct graduate medical education (GME) payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under the IPPS, and those that were once paid under the TEFRA rate of increase limits but are now paid under other PPSs. These direct GME payments are made separately from payments for hospital operating costs and are not part of the PPSs. However, the direct GME payments may not address the higher indirect operating costs which may often be experienced by teaching hospitals. For teaching hospitals paid under the TEFRA rate-of-increase limits, Medicare did not make separate medical education payments because payments to these hospitals were based on the hospitals' reasonable costs. Because payments under TEFRA were based on hospitals' reasonable costs, the higher indirect costs that might be associated with teaching programs would automatically have been factored into the TEFRA payments.

When the IRF PPS was implemented, we did not adjust payments to IRFs for indirect medical education costs because we did not find that adjustments for such costs were supported by the regression analyses or by the impact analyses. As discussed in the August 7, 2001 final rule (69 FR 41316, 41359), the indirect teaching variable was not significant for either the fully specified regression or the payment regression in RAND's analysis. Furthermore, the impacts among the various classes of facilities reflecting the fully phased-in IRF PPS illustrated that IRFs with the highest measure of indirect teaching would lose approximately 2 percent of estimated payments under the IRF PPS when compared with payments under TEFRA rate-of-increase limits. These impacts did not account for changes in behavior that facilities were likely to adopt in response to the inherent incentives of the IRF PPS, and we believed that IRFs could change their behavior to mitigate any potential reduction in payments.

The earlier research conducted by RAND was based on 1999 data and on a sample of IRFs. RAND recently conducted research to support us in developing potential refinements to the IRF classification system and the PPS. The regression analysis conducted by RAND for this proposed rule, using FY 2003 data, showed that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs.

In conducting the analysis on the FY 2003 data, RAND used the resident counts that were reported on the hospital cost reports (worksheet S–3, line 25, column 9 for freestanding IRF hospitals and worksheet S–3, Part 1, line 14 (or line 14.01 for subprovider 2), column 9 for rehabilitation units of acute care hospitals). That is, for the freestanding rehabilitation hospitals, RAND used the number of residents and interns reported for the entire hospital. For the rehabilitation units of acute care hospitals, RAND used the number of residents and interns reported for the rehabilitation unit (reported separately on the cost report from the number reported for the rest of the hospital). RAND did not distinguish between different types of resident specialties, nor did they distinguish among the different types of services residents provide, because this information is not reported on the cost reports.

RAND used regression analysis (with the logarithm of costs as the dependent variable) to re-examine the effect of IRFs' teaching status on the costs of care. With FY 2003 data that include all Medicare-covered IRF discharges, RAND found a statistically significant difference in costs between IRFs with teaching programs and those without teaching programs in the regression analysis. The different results obtained using the FY 2003 data (compared with the 1999 data) may be due to improvements in IRF coding after implementation of the IRF PPS. More accurately coded data may have allowed RAND to determine better the differences in case mix among hospitals with and without teaching programs, which would then have allowed the effect of whether or not an IRF has a teaching program to become significant in the regression analysis. There are two main reasons that indirect operating costs may be higher in teaching hospitals: (1) Because the teaching activities themselves result in inefficiencies that increase costs, and (2) because patients needing more costly services tend to be treated more often in teaching hospitals than in non-teaching hospitals, that is, the case mix that is drawn to teaching hospitals. Quantifying more precisely the amount of cost increase that is due to teaching hospitals' case mix allows RAND to more precisely quantify the amount of increase due to the inefficiencies associated with a teaching program.

We would propose to treat the teaching status adjustment as an additional payment to the Federal prospective payment rate, similar to the IME payments made under the IPPS (see § 412.105). Any such teaching status adjustments for the IRF PPS facilities would be made on a claim basis as interim payments, but the final payment in full for the cost reporting period would be made through the cost report. The difference between those interim payments and the actual teaching status adjustment amount computed in the cost report would be adjusted through lump sum payments/recoupments when the cost report is filed and later settled.

As in the IPF PPS, we would propose to calculate a teaching adjustment based on the IRF's ''teaching variable,'' which would be one plus the ratio of the number of FTE residents training in the IRF (subject to limitations described

further below) to the IRF's average daily census (ADC). In RAND's most recent cost regressions using data from FY 2003, the logarithm of the teaching variable has a coefficient value of 1.083. We would propose to convert this cost effect to a teaching status payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value—currently 1.083 (that is, the teaching status adjustment would be calculated by raising the teaching variable (1 + FTE residents/ADC) to the 1.083 power). For a facility with a teaching variable of 0.10, and using a coefficient based upon the coefficient value (1.083) from the FY 2003 data, this method would yield a 10.9 percent increase in the per discharge payment; for a facility with a teaching variable of 0.05, the payment would increase by 5.4 percent. We note that the coefficient value of 1.083 is based on regression analysis holding all other components of the payment system constant. Because we are proposing a number of other revisions to the payment system in this proposed rule, the coefficient value is subject to change for the final rule depending on the other revisions included in the final rule. Moreover, we are concerned that IRFs' responses to other proposed changes described in this proposed rule will influence the effects of a teaching variable on IRFs' costs.

In addition, the teaching adjustment we would propose would limit the incentives for IRFs to add FTE residents for the purpose of increasing their teaching adjustment, as has been done in the payment systems for psychiatric facilities and acute inpatient hospitals. Thus, we would propose to impose a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, similar to that established by sections 4621 (IME FTE cap for IPPS hospitals) and 4623 (direct GME FTE cap for all hospitals) of the BBA. We note that the FTE resident cap already applies to teaching hospitals, including IRFs, for purposes of direct GME payments as specified in § 413.75 through § 413.83. The proposed cap would limit the number of residents that teaching hospitals may count for the purposes of calculating the IRF PPS teaching status adjustment, not the number of residents teaching institutions can hire or train.

The proposed FTE resident cap would be identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. Similar to the regulations for counting FTE residents under the IPPS as described in § 412.105(f), we are proposing to calculate a number of FTE residents that trained in the IRF during a ''base year'' and use that FTE resident number as the cap. An IRF's FTE resident cap would ultimately be determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003. We would also propose that, similar to new IPPS teaching hospitals, IRFs that first begin training residents after November 15, 2003 would initially receive an FTE cap of ''0''. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in § 413.79(l)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in § 412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e) for IPPS hospitals. However, contrary to the policy for IME FTE resident caps under the IPPS, we would not allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. We are proposing these policies because we believe it is important to limit the total pool of resident FTE cap positions within the IRF community and avoid incentives for IRFs to add FTE residents in order to increase their payments. We also want to avoid the possibility of hospitals transferring residents between IPPS and IRF training settings in order to increase Medicare payments. We recognize that under the regulations applicable to the IPPS IME adjustment, a new teaching hospital that trains residents from an existing program (not a new program as defined in 42 CFR 413.79(l)) can receive an adjustment to its IME FTE cap by entering into a Medicare GME affiliation agreement (see § 412.105(f)(1)(vi), § 413.75(b), and § 413.79(f)) with other hospitals. However, this option would not be available to new teaching IRFs because, as noted above, we would propose not to allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching adjustment through affiliation agreements.

We would propose that residents with less than full-time status and residents rotating through the rehabilitation hospital or unit for less than a full year be counted in proportion to the time they spend in their assignment with the IRF (for example, a resident on a full-time, 3-month rotation to the IRF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS IME adjustment would be allowed to be counted for purposes of the teaching status adjustment for the IRF PPS.

The denominator that we would propose to use to calculate the teaching status adjustment under the IPF PPS would be the IRF's average daily census (ADC) from the current cost reporting period because it is closely related to the IRF's patient load, which determines the number of interns and residents the IRF can train. We also believe the ADC is a measure that can be defined precisely and is difficult to manipulate. Although the IPPS IME adjustment uses the hospital's number of beds as the denominator, the capital PPS (as specified at § 412.322) and the IPF PPS (as specified at § 412.424) both use the ADC as the denominator for the indirect graduate medical education adjustments.

If a rehabilitation hospital or unit has more FTE residents in a given year than in the base year (the base year being used to establish the cap), we would base payments in that year on the lower number (the cap amount). This approach would be consistent with the IME adjustment under the IPPS and the IPF PPS. The IRF would be free to add FTE residents above the cap amount, but it would not be allowed to count the number of FTE residents above the cap for purposes of calculating the teaching adjustment. This means that the cap would be an upper limit on the number of FTE residents that may be counted for purposes of calculating the teaching status adjustment. IRFs could adjust their number of FTE residents counted for purposes of calculating the teaching adjustment as long as they remained under the cap.

On the other hand, if a rehabilitation hospital or unit were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap), an adjustment in payments in that year would be based on the lower number (the actual number of FTE residents the facility hires and trains).

We would propose to implement a teaching status adjustment in such a way that total estimated aggregate payments to IRFs for FY 2006 would be the same with and without the proposed adjustment (that is, in a budget neutral manner). This is because we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS

payments during 2002 would have been 17 percent higher than IRFs' costs. We are open to examining other evidence regarding the amount of aggregate payments in the system.

Consideration of an adjustment to payments based on an IRF's teaching status is consistent with section 1886 (j)(3)(A)(v) of the Act, which confers broad statutory authority upon the Secretary to adjust the per payment unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

As mentioned above and discussed below, we have some concerns with implementing a teaching status adjustment for IRFs at this time. We are concerned about volatility in the data given the many changes to the IRF PPS that have been made in recent years and may be adopted in this rulemaking process. Other proposed payment policy changes have the potential to change the magnitude or even the effect of a teaching variable on costs once IRFs have fully responded to the other proposed policy changes in this proposed rule. We also believe it is important to ensure that the data accurately counts residents who provide services to IRF patients.

We note that the significant coefficient we found in the analysis of the FY 2003 data contrasts with the statistically insignificant coefficient we found in the analysis of the 1999 data used to construct the initial IRF PPS. Although we currently believe it may be appropriate to propose a teaching status adjustment for IRFs based on analysis of the FY 2003 data, we recognize that we may need to examine new data (that is, FY 2004 or later) to help us to reconcile these contradictory findings. We also believe the analysis of this new data could potentially lead us to conclude that a teaching status adjustment is not needed.

The results of RAND's analysis using FY 2003 data also show that certain refinements to the IRF case mix system (as discussed in section II of this proposed rule) would improve the system by more appropriately accounting for the variation in costs among different types of IRF patients. In this proposed rule, we propose numerous changes to the CMGs and tiers, and to the threshold amount used to determine whether cases qualify for outlier payments, in order to better align IRF payments with the costs of providing care to Medicare beneficiaries in IRFs. In addition, this proposed rule proposes substantial changes to the wage index (the adoption of CBSA market area definitions) and to the rural and the LIP adjustments. We believe that these proposed changes may have an impact on cost differences between teaching and non-teaching IRFs, and that we will be able to assess their impact on teaching and non-teaching IRFs only after the proposed changes have been implemented.

Furthermore, we believe it is important to ensure that the data accurately count residents who participate in managing the rehabilitation of IRF patients. We are particularly interested in ensuring that the FTE resident counts used for the proposed IRF teaching status adjustment do not duplicate resident counts used for purposes of the IPPS IME adjustment, and that hospitals do not have incentives to shift residents from the acute care hospital to the hospital's rehabilitation unit for purposes of computing the proposed IRF teaching adjustment. We are soliciting comments on the most valid and reliable method of counting residents for purposes of a proposed teaching status adjustment. We note that any changes we may make, based on our further investigation of this issue or on comments we receive on this proposed rule, to the methodology for counting residents could affect the magnitude of the proposed teaching adjustment or even whether the data continue to indicate that the proposed teaching status adjustment is appropriate.

In addition, we recognize that the proposed new teaching status adjustment, especially if implemented in a budget-neutral manner, is an important issue for all providers because it involves a redistribution of resources among facilities. That is, under the proposal, IRFs with teaching programs would receive additional payments, while IRFs without teaching programs would have their payments lowered to maintain total estimated payments for FY 2006 at the same level as without the proposed adjustment. For this reason, we believe caution is warranted in this case.

We are specifically soliciting comments on our consideration of the IRF teaching status adjustment.

4. Proposed Adjustment for Rural Location

Consistent with the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we adjust the Federal prospective payment amount associated with a CMG to account for an IRF's geographic wage variation, low-income patients and, if applicable, location in a rural area, as described in § 412.624(e).

Under the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we are proposing to increase the adjustment to the Federal prospective payment amount for IRFs located in rural areas from 19.14 percent to 24.1 percent. We are proposing this change because RAND's regression analysis, using the best available data we have (FY 2003), indicates that rural facilities now have 24.1 percent higher costs of caring for Medicare patients than urban facilities. We note that we propose to use the same statistical approach, as described in the November 3, 2000 proposed rule (65 FR 66304, 66356 through 66357) and adopted in the August 7, 2001 final rule (66 FR at 41359) to estimate the proposed update to the rural adjustment. The statistical approach RAND used both when the PPS was first implemented and for the proposed update described in this proposed rule relies on the coefficient determined from the regression analysis. The 19.14 percent rural adjustment has been applied to payments for IRFs located in rural areas since the implementation of the IRF PPS. We note that the FY 2003 data are the best available data we have, just as the 1998 and 1999 data used in the initial development of the IRF PPS were the best available data at that time.

We are proposing to implement the proposed update to the rural adjustment so that total estimated aggregate payments for FY 2006 are the same with the proposed update to the adjustment as they would have been without the proposed update to the adjustment (that is, in a budget neutral manner). We are proposing to make this proposed update to the rural adjustment in a budget neutral manner because we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data (as discussed previously in this proposed rule) suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. We are open to examining other evidence regarding the amount of estimated aggregate payments in the system.

This is consistent with section 1886(j)(3)(A)(v) of the Act which confers broad statutory authority upon the Secretary to adjust the per payment unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation

facilities. To ensure that total estimated aggregate payments to IRFs do not change, we propose to apply a factor to the standard payment conversion factor to assure that the estimated aggregate payments under this subsection in the FY are not greater or less than those that would have been made in the year without the proposed update to the adjustment. In sections III.B.7 and III.B.8 of this proposed rule, we discuss the methodology and factor we are proposing to apply to the standard payment amount.

5. Proposed Adjustment for Disproportionate Share of Low-Income Patients

Consistent with the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we adjust the Federal prospective payment amount associated with a CMG to account for an IRF's geographic wage variation, low-income patients and, if applicable, location in a rural area, as described in § 412.624(e).

Under the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we are proposing to update the low-income patient (LIP) adjustment to the Federal prospective payment rate to account for differences in costs among IRFs associated with differences in the proportion of low-income patients they treat. RAND's regression analysis of 2003 data indicates that the LIP formula could be updated to better distribute current payments among facilities according to the proportion of low-income patients they treat. Although the current formula appropriately distributed LIP-adjusted payments among facilities when the IRF PPS was first implemented, we believe the formula should be updated from time to time to reflect changes in the costs of caring for low-income patients.

The proposed LIP adjustment is based on the formula used to account for the costs of furnishing care to low-income patients as discussed in the August 7, 2001 final rule (67 FR at 41360). We propose to update the LIP adjustment from the power of 0.4838 to the power of 0.636. Therefore, the proposed formula to calculate the LIP adjustment would be as follows: (1 + DSH patient percentage) raised to the power of (.636) Where DSH patient percentage =

$$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, NonMedicare Days}}{\text{Total Days}}$$

We note that we propose to use the same statistical approach, as described in the August 7, 2001 final rule (66 FR at 41359 through 41360), that was used to develop the original LIP adjustment. We note that the FY 2003 data we propose to use in calculating this adjustment are the best available data, just as the 1998 and 1999 data used in the initial development of the IRF PPS were the best available data at that time.

We are proposing to implement the proposed update to the LIP adjustment so that total estimated aggregate payments for FY 2006 are the same with the proposed update to the adjustment as they would have been without the proposed update to the adjustment (that is, in a budget neutral manner). We are proposing to make this proposed update to the LIP adjustment in a budget neutral manner because we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data (as discussed previously in this proposed rule) suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. We are open to examining other evidence regarding the amount of estimated aggregate payments in the system.

This is consistent with section 1886 (j)(3)(A)(v) of the Act which confers broad statutory authority upon the Secretary to adjust the per payment unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. To ensure that total estimated aggregate payments to IRFs do not change, we propose to apply a factor to the standard payment conversion factor to assure that the estimated aggregate payments under this subsection in the FY are not greater or less than those that would have been made in the year without the proposed update to the adjustment. In sections III.B.7 and III.B.8 of this proposed rule, we discuss the methodology and factor we are proposing to apply to the standard payment amount.

6. Proposed Update to the Outlier Threshold Amount

Consistent with the broad statutory authority conferred upon the Secretary in sections 1886(j)(4)(A)(i) and 1886(j)(4)(A)(ii) of the Act, we are proposing to update the outlier threshold amount from the $11,211 threshold amount for FY 2005 to $4,911 in FY 2006 to maintain total estimated outlier payments at 3 percent of total estimated payments. In the August 7, 2001 final rule, we discuss our rationale for setting estimated outlier payments at 3 percent of total estimated payments (66 FR at 41362). We continue to propose to use 3 percent for the same reasons outlined in the August 7, 2001 final rule. We believe it is necessary to update the outlier threshold amount because RAND's analysis of the calendar year 2002 and FY 2003 data indicates that total estimated outlier payments will not equal 3 percent of total estimated payments unless we update the outlier loss threshold. We will continue to analyze the estimated outlier payments for subsequent years and adjust as appropriate in order to maintain estimated outlier payments at 3 percent of total estimated payments. The reasons for estimated outlier payments not equaling 3 percent of total estimated payments are discussed in more detail below.

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 final rule, we codified at § 412.624(e)(4) of the regulations (which would be redesignated as § 412.624(e)(5)) the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in determining resource costs at the patient and facility level because facilities receive additional compensation over and above the adjusted Federal prospective payment amount for uniquely high-cost cases. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under § 412.624(e)(4) (which would be redesignated as § 412.624(e)(5)), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount (we are proposing to make this $4,911, which is then adjusted for each IRF by the facility's wage adjustment, its LIP adjustment, its rural adjustment, and its teaching status adjustment, if applicable). We calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.624(e)(4), we pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted fixed threshold dollar amount).

Consistent with the broad statutory authority conferred upon the Secretary in sections 1886(j)(4)(A)(i) and 1886(j)(4)(A)(ii) of the Act, and in accordance with the methodology stated in the August 1, 2003 final rule (68 FR at 45692 through 45693), we propose to continue to apply a ceiling to an IRF's cost-to-charge ratios (CCR). Also, in the August 1, 2003 final rule (68 FR at 45693 through 45694), we stated the methodology we use to adjust IRF outlier payments and the methodology we use to make these adjustments. We indicated that the methodology is codified in § 412.624(e)(4) (which would be redesignated as § 412.624(e)(5)) and § 412.84(i)(3).

On February 6, 2004, we issued manual instructions in Change Request 2998 stating that we would set forth the upper threshold (ceiling) and the national CCRs applicable to IRFs in each year's annual notice of prospective payment rates published in the **Federal Register**. The upper threshold CCR for IRFs that we are proposing for FY 2006 would be 1.52 based on CBSA-based geographic designations. We are proposing to base this upper threshold CCR on the CBSA-based geographic designations because the CBSAs are the geographic designations we are proposing to adopt for purposes of computing the proposed wage index adjustment to IRF payments for FY 2006. If, instead, we were to use the MSA geographic designations, the upper threshold CCR amount would likely be different than the 1.52 we are proposing above. In addition, this is an estimated threshold and is subject to change in the final rule based on more recent data.

In addition, we are proposing to update the national urban and rural CCRs for IRFs. Under § 412.624(e)(4) (which would be redesignated as § 412.624(e)(5)) and § 412.84(i)(3), we are proposing to apply the national CCRs to the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.
- IRFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean.
- Other IRFs for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital CCR (or both) are not available.

The national CCR based on the facility location of either urban or rural would be used in each of the three situations cited above. Specifically, for FY 2006, we have estimated a proposed national CCR of 0.631 for rural IRFs and 0.518 for urban IRFs. For new facilities, we are proposing to use these national ratios until the facility's actual CCR can be computed using the first tentative settled or final settled cost report data, which will then be used for the subsequent cost report period.

In the August 7, 2001 final rule (66 FR at 41362 through 41363), we describe the process by which we calculate the outlier threshold. We continue to use this process for this proposed rule. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being equal to 3 percent of total simulated payments under the simulation. We note that the simulation analysis used to calculate the proposed $4,911 outlier threshold includes all of the proposed changes to the PPS discussed in this proposed rule, and is therefore subject to change in the final rule depending on the policies contained in the final rule. In addition, we will continue to analyze the estimated outlier payments for subsequent years and adjust as appropriate in order to maintain estimated outlier payments at 3 percent of total estimated payments.

In this proposed rule, we are proposing to update the threshold amount to $4,911 so that outlier payments will continue to equal 3 percent of total estimated payments under the IRF PPS. RAND found that 2002 outlier payments were equal to 3.1 percent of total payments in 2002. Nevertheless, the outlier loss threshold is affected by cost-to-charge ratios because the cost-to-charge ratios are used to compute the estimated cost of a case, which in turn is used to determine if a particular case qualifies for an outlier payment or not. For example, if the cost-to-charge ratio decreases, then the estimated costs of a case with the same reported charges would decrease. Thus, the chances that the case would exceed the outlier loss threshold and qualify for an outlier payment would decrease, decreasing the likelihood that the case would qualify for an outlier payment. If fewer cases were to qualify for outlier payments, then total estimated outlier payments could fall below 3 percent of total estimated payments.

Our analyses of cost report data from FY 1999 through FY 2002 (and projections for FY 2004 though FY 2006) indicate that the overall cost-to-charge ratios in IRFs have been falling since the IRF PPS was implemented. We are still analyzing possible reasons for this finding. However, because cost-to-charge ratios are used to determine whether a particular case qualifies for an outlier payment, this drop in the cost-to-charge ratios is likely responsible for much of the drop in total estimated outlier payments below 3 percent of total estimated payments. Thus, the outlier threshold would need to be lowered from $11,211 to $4,911 for FY 2006 in order that total estimated outlier payments would equal 3 percent of total estimated payments.

In addition, we are proposing to adjust the outlier threshold for FY 2006 because RAND's analysis of calendar year 2002 and FY 2003 data indicates that many of the other proposed changes discussed in this proposed rule would affect what the outlier threshold would need to be in order for total estimated outlier payments to equal 3 percent of total estimated payments. The outlier loss threshold is affected by the definitions of all other elements of the IRF PPS, including the structure of the CMGs and the tiers, the relative weights, the policies for very short-stay cases and for cases in which the patient expires in the facility (that is, cases that qualify for the special CMG assignments), and the facility-level adjustments (such as the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment). In this proposed rule, we are proposing to change many of these components of the IRF PPS. For the reasons discussed above, then, we believe it is appropriate to update the outlier loss threshold for FY 2006. We expect to continue to adjust the outlier threshold in the future when the data indicate that total estimated outlier payments would deviate from equaling 3 percent of total estimated payments.

7. Proposed Budget Neutrality Factor Methodology for Fiscal Year 2006

We are proposing to make a one-time revision (for FY 2006) to the methodology found in § 412.624(d) in

order to make the proposed changes to the tiers and CMGs, the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment in a budget neutral manner. Accordingly, we are proposing to revise § 412.624(d) by adding a section § 412.624(d)(4) for fiscal year 2006. Specifically, we are proposing to revise the methodology found in § 412.624(d) by adding a new paragraph (d)(4). The addition of this paragraph would provide for the application of a factor, as specified by the Secretary, which would be applied to the standard payment amount in order to make the proposed changes described in this preamble in a budget neutral manner for FY 2006. In addition, this paragraph would be used in future years if we propose refinements to the above-cited adjustments. According to the revised methodology, we propose to apply the market basket increase factor (3.1 percent) to the standard payment conversion factor for FY 2005 ($12,958), which equals $13,360. Then, we propose a one-time reduction to the standard payment amount of 1.9 percent to adjust for coding changes that increased payment to IRFs (as discussed in section III.A of this proposed rule), which equals $13,106. We then propose to apply the budget neutral wage adjustment (as discussed in section III.B.2.f of this proposed rule) of 0.9996 to $13,106, which would result in a standard payment amount of $13,101. For FY 2006 only, we propose to change the methodology for computing the standard payment conversion factor by applying budget neutrality factors for the proposed changes to the tiers and CMGs, the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment. The next section contains a detailed explanation of these proposed budget neutrality factors, including the steps for computing these factors and how they affect total estimated aggregate payments and payments to individual IRF providers. The factors we are proposing to apply (as discussed in the next section) are 0.9994 for the proposed tier and CMG changes, 0.9865 for the proposed teaching status adjustment, 0.9963 for the proposed change to the rural adjustment, and 0.9836 for the proposed change to the LIP adjustment. These factors are subject to change as we analyze more current data. We have combined these factors, by multiplying the four factors together, into one budget neutrality factor for all four of these proposed changes (0.9994 * 0.9865 * 0.9963 * 0.9836 = 0.9662). We apply this overall budget neutrality factor to $13,101, resulting in a standard payment conversion factor for FY 2006 of $12,658. Note that the FY 2006 standard payment conversion factor is lower than it was in FY 2005 because it needed to be reduced to ensure that estimated aggregate payments for FY 2006 would remain the same as they otherwise would have been without the proposed changes. If we did not proposed to decrease the standard payment conversion factor, each of the proposed changes would increase total estimated aggregate payments by increasing payments to rural and teaching facilities, and to facilities with a higher average case mix of patients and facilities that treat a higher proportion of low-income patients. To assess how overall payments to a particular type of IRF would likely be affected by the proposed budget-neutral changes, please see Table 13 of this proposed rule.

The FY 2006 standard payment conversion factor would be applied to each CMG relative weight shown in Table 6, Proposed Relative Weights for Case-Mix Groups, to compute the proposed unadjusted IRF prospective payment rates for FY 2006 shown in Table 12. To further clarify, the proposed one-time budget neutrality factors described above will only be applied for FY 2006. In addition, if no further refinements are proposed for subsequent fiscal years, we will use the methodology as described in § 412.624(c)(3)(ii).

8. Description of the Methodology Used To Implement the Proposed Changes in a Budget Neutral Manner

Section 1886(j)(2)(C)(i) of the Act confers broad statutory authority upon the Secretary to adjust the classification and weighting factors in order to account for relative resource use. In addition, section 1886(j)(2)(C)(ii) provides that insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregated payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years to eliminate the effect of such coding or classification changes. Similarly, section 1886(j)(3)(A)(v) of the Act confers broad statutory authority upon the Secretary to adjust the per discharge payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among IRFs. Consistent with this broad statutory authority, we are proposing to better distribute aggregate payments among IRFs to more accurately reflect their case mix and the increased costs associated with IRFs that have teaching programs, are located in rural areas, or treat a high proportion of low-income patients.

To ensure that total estimated aggregate payments to IRFs do not change with these proposed changes, we propose to apply a factor to the standard payment amount for each of the proposed changes to ensure that estimated aggregate payments in FY 2006 are not greater or less than those that would have been made in the year without the proposed changes. We propose to calculate these four factors using the following steps:

Step 1: Determine the FY 2006 IRF PPS standard payment amount using the FY 2005 standard payment conversion factor increased by the estimated market basket of 3.1 percent and reduced by 1.9 percent to account for coding changes (as discussed in section III.A of this proposed rule).

Step 2: Multiply the CBSA-based budget neutrality factor discussed in this preamble by the standard payment amount computed in step 1 to account for the wage index and labor-related share (0.9996), as discussed in section III.B.2.f of this proposed rule.

Step 3: Calculate the estimated total amount of IRF PPS payments for FY 2006 (with no change to the tiers and CMGs, no teaching status adjustment, and no changes to the rural and LIP adjustments).

Step 4: Apply the proposed new tier and CMG assignments (as discussed in section II) to calculate the estimated total amount of IRF PPS payments for FY 2006.

Step 5: Divide the amount calculated in step 3 by the amount calculated in step 4 to determine the factor (currently estimated to be 0.9994) that maintains the same total estimated aggregate payments in FY 2006 with and without the proposed changes to the tier and CMG assignments.

Step 6: Apply the factor computed in step 5 to the standard payment amount from step 2, and calculate estimated total IRF PPS payment for FY 2006.

Step 7: Apply the proposed change to the rural adjustment (as discussed in section III.B.4 of this proposed rule) to calculate the estimated total amount of IRF PPS payments for FY 2006.

Step 8: Divide the amount calculated in step 6 by the amount calculated in step 7 to determine the factor (currently estimated to be 0.9963) that keeps total estimated payments in FY 2006 the

same with and without the proposed change to the rural adjustment.

Step 9: Apply the factor computed in step 8 to the standard payment amount from step 6, and calculate estimated total IRF PPS payment for FY 2006.

Step 10: Apply the proposed change to the LIP adjustment (as discussed in section III.B.5 of this proposed rule) to calculate the estimated total amount of IRF PPS payments for FY 2006.

Step 11: Divide the amount calculated in step 9 by the amount calculated in step 10 to determine the factor (currently estimated to be 0.9836) that maintains the same total estimated aggregate payments in FY 2006 with and without the proposed change to the LIP adjustment.

Step 12: Apply the factor computed in step 11 to the standard payment amount from step 9, and calculate estimated total IRF PPS payment for FY 2006.

Step 13: Apply the proposed teaching status adjustment (as discussed in section III.B.5 of this proposed rule) to calculate the estimated total amount of IRF PPS payments for FY 2006.

Step 14: Divide the amount calculated in step 12 by the amount calculated in step 13 to determine the factor (currently estimated to be 0.9865) that maintains the same total estimated aggregate payments in FY 2006 with and without the proposed teaching status adjustment.

As discussed in section III.B.9 of this proposed rule, the proposed FY 2006 IRF PPS standard payment conversion factor that accounts for the proposed new tier and CMG assignments, the proposed changes to the rural and the LIP adjustments, and the proposed teaching status adjustment applies the following factors: the market basket update, the reduction of 1.9 percent to account for coding changes, the budget-neutral CBSA-based wage index and labor-related share budget neutrality factor of 0.9996, the proposed tier and CMG changes budget neutrality factor of 0.9994, the proposed rural adjustment budget neutrality factor of 0.9963, the proposed LIP adjustment budget neutrality factor of 0.9836, and the proposed teaching status adjustment budget neutrality factor of 0.9865.

Each of these proposed budget neutrality factors lowers the proposed standard payment amount. The budget neutrality factor for the proposed tier and CMG changes lowers the standard payment amount from $13,101 to $13,093. The budget neutrality factor for the proposed change to the rural adjustment lowers the standard payment amount from $13,093 to $13,045. The budget neutrality factor for the proposed change to the LIP adjustment lowers the standard payment amount from $13,045 to $12,831. Finally, the budget neutrality factor for the proposed teaching status adjustment lowers the standard payment amount from $12,831 to $12,658. As indicated previously, the standard payment conversion factor would need to be lowered in order to ensure that total estimated payments for FY 2006 with the proposed changes equal total estimated payments for FY 2006 without the proposed changes. This is because these four proposed changes would result in an increase, on average, to total estimated aggregate payments to IRFs, because IRFs with teaching programs, IRFs located in rural areas, IRFs with higher case mix, and IRFs with higher proportions of low-income patients would receive higher payments. To maintain the same total estimated aggregate payments to all IRFs, then, we are proposing to redistribute payments among IRFs. Thus, some redistribution of payments occurs among facilities, while total estimated aggregate payments do not change. To determine how these proposed changes are estimated to affect payments among different types of facilities, please see Table 13 in this proposed rule.

9. Description of the Proposed IRF Standard Payment Conversion Factor for Fiscal Year 2006

In the August 7, 2001 final rule, we established a standard payment amount referred to as the budget neutral conversion factor under § 412.624(c). In accordance with the methodology described in § 412.624(c)(3)(i), the budget neutral conversion factor for FY 2002, as published in the August 7,2001 final rule, was $11,838.00. Under § 412.624(c)(3)(i), this amount reflects, as appropriate, any adjustments for outlier payments, budget neutrality, and coding and classification changes as described in § 412.624(d).

The budget neutral conversion factor is a standardized payment amount and the amount reflects the budget neutrality adjustment for FY 2002. The statute required a budget neutrality adjustment only for FYs 2001 and 2002. Accordingly, we believed it was more consistent with the statute to refer to the standard payment as a standard payment conversion factor, rather than refer to it as a budget neutral conversion factor. Consequently, we changed all references to budget neutral conversion factor to ''standard payment conversion factor.''

Under § 412.624(c)(3)(i), the standard payment conversion factor for FY 2002 of $11,838.00 reflected the budget neutrality adjustment described in § 412.624(d)(2). Under the then existing § 412.624(c)(3)(ii), we updated the FY 2002 standard payment conversion factor ($11,838.00) to FY 2003 by applying an increase factor (the market basket) of 3.0 percent, as described in the update notice published in the August 1, 2002 **Federal Register** (67 FR at 49931). This yielded the FY 2003 standard payment conversion factor of $12,193.00 that was published in the August 1, 2002 update notice (67 FR at 49931). The FY 2003 standard payment conversion factor ($12,193) was used to update the FY 2004 standard payment conversion factor by applying an increase factor (the market basket) of 3.2 percent and budget neutrality factor of 0.9954, as described in the August 1, 2003 **Federal Register** (68 FR at 45689). This yielded the FY 2004 standard payment conversion factor of $12,525 that was published in the August 1, 2003 **Federal Register** (68 FR at 45689). The FY 2004 standard payment conversion factor ($12,525) was used to update the FY 2005 standard payment conversion factor by applying an increase factor (the market basket) of 3.1 percent and budget neutrality factor of 1.0035, as described in the July 30, 2004 **Federal Register** (69 FR at 45766). This yielded the FY 2005 standard payment conversion factor of $12,958 as published in the July 30, 2004 **Federal Register** (69 FR at 45766).

We propose to use the revised methodology in accordance with § 412.624(c)(3)(ii)and as described in section III.B.7 of this proposed rule. To calculate the standard payment conversion factor for FY 2006, we are proposing to apply the market basket increase factor (3.1 percent) to the standard payment conversion factor for FY 2005 ($12,958), which equals $13,360. Then, we propose a one-time reduction to the standard payment amount of 1.9 percent to adjust for coding changes that increased payment to IRFs, which equals $13,106. We then propose to apply the budget neutral wage adjustment of 0.9996 to $13,106, which would result in a standard payment amount of $13,101. Next, we propose to apply a one-time budget neutrality factor (for FY 2006 only) for the proposed budget neutral refinements to the tiers and CMGs, the teaching status adjustment, the rural adjustment, and the adjustment for the proportion of low-income patients (of 0.9662) to $13,101, which would result in a standard payment conversion factor for FY 2006 of $12,658. The FY 2006 standard payment conversion factor would be applied to each CMG weight

shown in Table 6, Proposed Relative Weights for Case-Mix Groups, to compute the unadjusted IRF prospective payment rates for FY 2006 shown in Table 12.

10. Example of the Proposed Methodology for Adjusting the Federal Prospective Payment Rates

To illustrate the methodology that we propose to use to adjust the Federal prospective payments (as described in section III.B.7 and section III.B.8 of this proposed rule), we provide an example in Table 11 below.

One beneficiary is in Facility A, an IRF located in rural Montana, and another beneficiary is in Facility B, an IRF located in the New York City core-based statistical area. Facility A, a non-teaching hospital, has a disproportionate share hospital (DSH) adjustment of 5 percent, with a low-income patient adjustment of (1.0315), a wage index of (0.8701), and an applicable rural area adjustment (24.1 percent). Facility B, a teaching hospital, has a DSH of 15 percent, with a LIP adjustment of (1.0929), a wage index of (1.3311), and an applicable teaching status adjustment of (1.109).

Both Medicare beneficiaries are classified to CMG 0110 (without comorbidities). To calculate each IRF's total proposed adjusted Federal prospective payment, we compute the wage-adjusted Federal prospective payment and multiply the result by the appropriate low-income patient adjustment, the rural adjustment (if applicable), and the teaching hospital adjustment (if applicable). Table 11 illustrates the components of the proposed adjusted payment calculation.

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Table 11--Example of Computing an IRF's Proposed Federal Prospective Payment

	Facility A	Facility B
Federal Prospective Payment	$27,450.14	$27,450.14
Labor Share	X 0.75958	X 0.75958
Labor Portion of Federal Payment	$20,850.58	$20,850.58
CBSA Based Wage Index (shown in Appendix 1, Tables 2(a) and 2(b))	X 0.8701	X 1.3311
Wage-Adjusted Amount	= $18,142.09	= $27,754.21
Nonlabor Amount	+ $6,599.55	+ $6,599.55
Wage-Adjusted Federal Payment	= $24,741.64	= $34,353.76
Rural Adjustment	X 1.241	X 1.0000
Subtotal	= $30,704.38	= $34,353.76
LIP Adjustment	X 1.0315	X 1.0929
	= $ 31,671.57	= $37,545.22
Teaching status addition	X 1.000	X 1.109
Total FY 2006 Adjusted Federal Prospective Payment	$31,671.57	$41,637.65

Thus, the proposed adjusted payment for Facility A would be $31,671.57, and the adjusted payment for Facility B would be $41,637.65.

Table 12: Proposed FY 2006 Payment Rate Table Based On All Proposed Refinements

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$9,735.27	$9,239.07	$8,207.45	$8,037.83
0102	$11,988.39	$11,378.28	$10,107.41	$9,898.56
0103	$14,128.86	$13,409.89	$11,912.44	$11,666.88
0104	$15,011.12	$14,246.58	$12,656.73	$12,394.71
0105	$18,016.13	$17,099.69	$15,190.87	$14,876.95
0106	$20,970.51	$19,903.44	$17,681.96	$17,316.14
0107	$24,203.36	$22,971.74	$20,407.23	$19,986.98
0108	$27,981.77	$26,557.75	$23,593.25	$23,105.91
0109	$27,817.22	$26,402.06	$23,454.01	$22,970.47
0110	$33,242.44	$31,551.33	$28,028.61	$27,450.14
0201	$10,303.61	$8,640.35	$7,621.38	$7,149.24
0202	$13,211.15	$11,079.55	$9,771.98	$9,165.66
0203	$15,806.04	$13,255.46	$11,690.93	$10,966.89
0204	$16,906.02	$14,178.23	$12,504.84	$11,730.17
0205	$20,735.07	$17,389.56	$15,336.43	$14,385.82
0206	$27,061.54	$22,695.79	$20,017.36	$18,775.61
0207	$35,008.23	$29,358.97	$25,894.47	$24,288.17
0301	$14,294.68	$12,070.67	$10,683.35	$9,827.67
0302	$18,643.97	$15,744.02	$13,933.93	$12,817.49
0303	$22,246.44	$18,785.74	$16,627.55	$15,294.66
0304	$30,658.94	$25,889.41	$22,914.78	$21,076.84
0401	$12,520.03	$10,780.82	$9,690.96	$8,654.27
0402	$17,265.51	$14,868.09	$13,364.32	$11,933.96
0403	$30,053.89	$25,880.55	$23,264.14	$20,774.31
0404	$53,881.31	$46,399.16	$41,708.11	$37,244.90
0405	$41,109.39	$35,400.63	$31,820.95	$28,415.94
0501	$9,752.99	$8,163.14	$7,140.38	$6,403.68
0502	$13,057.99	$10,928.92	$9,560.59	$8,574.53
0503	$17,311.08	$14,488.35	$12,674.46	$11,365.62
0504	$21,670.50	$18,136.38	$15,865.54	$14,227.59
0505	$25,681.82	$21,494.55	$18,803.46	$16,861.72
0506	$34,944.94	$29,247.57	$25,584.35	$22,943.89

Table 12: Proposed FY 2006 Payment Rate Table Based On All Proposed Refinements

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0601	$11,347.90	$9,279.58	$8,817.56	$8,218.84
0602	$15,094.67	$12,344.08	$11,730.17	$10,931.45
0603	$19,323.70	$15,802.25	$15,016.19	$13,994.68
0604	$24,732.47	$20,226.22	$19,218.64	$17,912.34
0701	$11,461.82	$9,792.23	$9,196.04	$8,335.29
0702	$14,882.01	$12,713.70	$11,939.03	$10,821.32
0703	$18,526.25	$15,827.56	$14,863.02	$13,471.91
0704	$22,736.30	$19,423.70	$18,240.18	$16,533.88
0801	$8,304.91	$6,975.82	$6,466.97	$5,817.62
0802	$10,847.91	$9,111.23	$8,446.68	$7,599.86
0803	$16,084.52	$13,508.62	$12,523.83	$11,266.89
0804	$14,011.14	$11,766.88	$10,908.66	$9,815.01
0805	$17,641.45	$14,816.19	$13,736.46	$12,358.01
0806	$21,171.77	$17,780.69	$16,484.51	$14,830.11
0901	$10,647.91	$9,693.50	$8,613.77	$7,708.72
0902	$13,992.15	$12,737.75	$11,318.78	$10,128.93
0903	$18,459.16	$16,804.76	$14,932.64	$13,363.05
0904	$23,140.09	$21,066.71	$18,718.65	$16,751.60
1001	$12,199.78	$11,250.43	$10,039.06	$9,255.53
1002	$16,087.05	$14,833.91	$13,236.47	$12,203.58
1003	$22,627.44	$20,864.18	$18,618.65	$17,165.51
1101	$15,878.20	$13,285.84	$11,631.44	$10,711.20
1102	$23,771.72	$19,889.52	$17,412.34	$16,035.15
1201	$12,890.91	$11,131.45	$10,260.57	$9,261.86
1202	$16,684.51	$14,408.60	$13,280.77	$11,987.13
1203	$20,554.06	$17,749.05	$16,360.47	$14,766.82
1301	$13,085.84	$12,173.20	$10,537.79	$9,313.76
1302	$18,131.32	$16,866.79	$14,599.74	$12,904.83
1303	$23,174.27	$21,559.11	$18,661.69	$16,495.91
1401	$10,344.12	$9,306.16	$8,096.06	$7,349.23
1402	$13,966.84	$12,564.33	$10,931.45	$9,922.61
1403	$17,385.76	$15,640.22	$13,607.35	$12,352.94
1404	$22,048.97	$19,836.35	$17,256.65	$15,665.54
1501	$11,673.21	$11,385.87	$9,730.20	$9,363.12

Table 12: Proposed FY 2006 Payment Rate Table Based On All Proposed Refinements

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1502	$14,757.96	$14,393.41	$12,301.04	$11,837.76
1503	$18,061.70	$17,616.14	$15,055.43	$14,487.08
1504	$23,812.23	$23,224.90	$19,849.01	$19,099.66
1601	$12,740.28	$10,815.00	$9,785.90	$8,739.08
1602	$17,480.70	$14,840.24	$13,426.34	$11,990.92
1603	$21,503.41	$18,254.10	$16,516.16	$14,750.37
1701	$12,787.11	$12,194.72	$10,535.25	$9,266.92
1702	$16,841.47	$16,060.47	$13,875.70	$12,206.11
1703	$20,040.15	$19,111.05	$16,509.83	$14,523.79
1704	$25,072.97	$23,909.70	$20,656.59	$18,170.56
1801	$15,338.96	$12,445.35	$10,436.52	$9,217.56
1802	$24,537.53	$19,908.50	$16,695.90	$14,745.30
1803	$44,029.59	$35,723.41	$29,958.95	$26,459.02
1901	$15,647.82	$13,899.75	$13,514.95	$11,833.96
1902	$29,318.46	$26,042.57	$25,321.06	$22,170.49
1903	$42,327.09	$37,598.06	$36,557.57	$32,008.28
2001	$11,066.89	$9,350.46	$8,383.39	$7,654.29
2002	$14,490.88	$12,242.82	$10,975.75	$10,021.34
2003	$18,719.92	$15,816.17	$14,179.49	$12,945.34
2004	$25,007.14	$21,128.73	$18,941.43	$17,294.63
2101	$27,667.86	$27,667.86	$20,138.88	$18,685.74
5001	$0.00	$0.00	$0.00	$2,786.03
5101	$0.00	$0.00	$0.00	$8,039.10
5102	$0.00	$0.00	$0.00	$20,255.33
5103	$0.00	$0.00	$0.00	$9,118.82
5104	$0.00	$0.00	$0.00	$23,760.33

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IV. Provisions of the Proposed Regulations

(If you choose to comment on issues in this section, please include the caption ''Provisions of the Proposed Regulations'' at the beginning of your comments.)

We are proposing to make revisions to the regulation in order to implement the proposed prospective payment for IRFs for FY 2006 and subsequent fiscal years. Specifically, we are proposing to make conforming changes in 42 CFR part 412. These proposed revisions and others are discussed in detail below.

A. Section 412.602 Definitions

In § 412.602, we are proposing to revise the definitions of ''Rural area'' and ''Urban area'' to read as follows:

Rural area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii). For discharges occurring on or after October 1, 2005, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

Urban area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(ii). For discharges occurring on or after October 1, 2005, urban area means an area as defined in § 412.64(b)(1)(ii)(A) and § 412.64(b)(1)(ii)(B).

B. Section 412.622 Basis of payment

In this section, we are proposing to correct the cross references in paragraphs (b)(1) and (b)(2)(i). In paragraph (b)(1), we are proposing to remove the cross references ''§§ 413.85 and 413.86 of this chapter'' and add in their place ''§ 413.75 and § 413.85 of this chapter.'' In paragraph (b)(2)(i), we are proposing to remove the cross reference ''§ 413.80 of this chapter'' and add in its place ''§ 413.89 of this chapter.''

C. Section 412.624 Methodology for calculating the Federal prospective payment rates.

- In paragraph (d)(1), removing the cross reference to ''paragraph (e)(4)'' and adding in its place ''paragraph (e)(5).''
- Adding a new paragraph (d)(4).
- Redesignating paragraphs (e)(4) and (e)(5) as paragraphs (e)(5) and (e)(6).
- Adding a new paragraph (e)(4).
- Revising newly redesignated paragraph (e)(5).
- Revising newly redesignated paragraph (e)(6).
- In paragraph (f)(2)(v), removing the cross references to ''paragraphs (e)(1), (e)(2), and (e)(3) of this section'' and adding in their place ''paragraphs (e)(1), (e)(2), (e)(3), and (e)(4) of this section.''

D. Additional Changes

- Reduce the standard payment conversion factor by 1.9 percent to account for coding changes.
- Revise the comorbidity tiers and CMGs.
- Use a weighted motor score index in assigning patients to CMGs.
- Update the relative weights.
- Update payments for rehabilitation facilities using a market basket reflecting the operating and capital cost structures for the RPL market basket.
- Provide the weights and proxies to use for the FY 2002-based RPL market basket.
- Indicate the methodology for the capital portion of the RPL market basket.
- Adopt the new geographic labor market area definitions as specified in § 412.64(b)(1)(ii)(A)–(C).
- Use the New England MSAs as determined under the proposed new CBSA-based labor market area definitions.
- Use FY 2001 acute care hospital wage data in computing the FY 2006 IRF PPS payment rates.
- Implement a teaching status adjustment.
- Update the formulas used to compute the rural and the LIP adjustments to IRF payments.
- Update the outlier threshold amount to maintain total outlier payments at 3 percent of total estimated payments.
- Revise the methodology for computing the standard payment conversion factor (for FY 2006 only) to make the proposed CMG and tier changes, the proposed teaching status adjustment, and the proposed updates to the rural and LIP adjustments in a budget neutral manner.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Response to Comments

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

VII. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''Regulatory Impact Analysis'' at the beginning of your comments.]

A. Introduction

The August 7, 2001 final rule established the IRF PPS for the payment of Medicare services for cost reporting periods beginning on or after January 1, 2002. We incorporated a number of elements into the IRF PPS, such as case-level adjustments, a wage adjustment, an adjustment for the percentage of low-income patients, a rural adjustment, and outlier payments. This proposed rule sets forth updates of the IRF PPS rates contained in the August 7, 2001 final rule and proposes policy changes with regard to the IRF PPS based on analyses conducted by RAND under contract with us on calendar year 2002 and FY 2003 data (updated from the 1999 data used to design the IRF PPS).

In constructing these impacts, we do not attempt to predict behavioral responses, nor do we make adjustments for future changes in such variables as discharges or case-mix. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, or new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) and Impact on Small Hospitals (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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 estimate that the cost to the Medicare program for IRF services in FY 2006 will increase by $180 million over FY 2005 levels. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. We are proposing to make changes to the CMGs and the tiers, the teaching status adjustment, and the rural and LIP adjustments in a budget neutral manner (that is, in order that total estimated aggregate payments with the changes equal total estimated aggregate payments without the changes). This means that we are proposing to improve the distribution of payments among facilities depending on the mix of patients they treat, their teaching status, their geographic location (rural vs. urban), and the percentage of low-income patients they treat, without changing total estimated aggregate

payments. To accomplish this redistribution of payments among facilities, we lower the base payment amount, which then gets adjusted upward for each facility according to the facility's characteristics. This proposed redistribution would not, however, affect aggregate payments to facilities. Thus, the proposed changes to the IRF labor-related share and the wage indices, the proposed changes to the CMGs, the tiers, and the motor score index, the proposed teaching status adjustment, the proposed update to the rural adjustment, and the proposed update to the LIP adjustment would have no overall effect on estimated costs to the Medicare program. Therefore, the estimated increased cost to the Medicare program is due to the updated IRF market basket of 3.1 percent, the 1.9 percent reduction to the standard payment conversion factor to account for changes in coding that affect total aggregate payments, and the update to the outlier threshold amount. We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.9 percent increase), we estimate that the total impact of these proposed changes for FY 2006 payments compared to FY 2005 payments would be approximately a $180 million increase. This amount does not reflect changes in IRF admissions or case-mix intensity, which would also affect overall payment changes.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze the economic impact of our regulations on small entities. If we determine that the proposed regulation would impose a significant burden on a substantial number of small entities, we must examine options for reducing the burden. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most IRFs and most other providers and suppliers are considered small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's regulation that set forth size standards for health care industries at 65 at FR 69432.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs (approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities for the purpose of the analysis that follows. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

3. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed 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 previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions that we are proposing to adopt, we would no longer employ NECMAs to define urban areas in New England. Therefore, for purposes of this analysis, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA).

As discussed in detail below, the rates and policies set forth in this proposed rule would not have an adverse impact on rural hospitals based on the data of the 169 rural units and 21 rural hospitals in our database of 1,188 IRFs for which data were available.

4. Unfunded Mandates Reform Act

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 proposed rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least $110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

5. Executive Order 13132

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it would not have any negative impact on the rights, roles, or responsibilities of State, local, or tribal governments.

6. Overall Impact

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. We have determined that the proposed rule would have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

B. Anticipated Effects of the Proposed Rule

We discuss below the impacts of this proposed rule on the budget and on IRFs.

1. Basis and Methodology of Estimates

In this proposed rule, we are proposing policy changes and payment rate updates for the IRF PPS. Based on the overall percentage change in payments per discharge estimated using a payment simulation model developed by RAND under contract with CMS (a 2.9 percent increase), we estimate the total impact of these proposed changes for FY 2006 payments compared to FY 2005 payments to be approximately a $180 million increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of each of the proposed changes to the IRF PPS. RAND's payment simulation model relies on the most recent available data (FY 2003) to enable us to estimate the impacts on payments per discharge of certain changes we are proposing in this proposed rule.

The data used in developing the quantitative analyses of changes in payments per discharge presented below are taken from the FY 2003 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Data from the most recently available IRF cost reports were used to estimate costs and to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IRF PPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change.

Using cases in the FY 2003 MedPAR file, we simulated payments under the IRF PPS given various combinations of payment parameters.

The proposed changes discussed separately below are the following:

- The effects of the proposed annual market basket update (using the proposed rehabilitation hospital, psychiatric hospital, and long-term care hospital (RPL) market basket) to IRF PPS payment rates required by sections 1886(j)(3)(A)(i) and 1886(j)(3)(C) of the Act.
- The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed decrease to the standard payment conversion factor to account for the increase in estimated aggregate payments due to changes in coding, as required under section 1886(j)(2)(C)(ii) of the Act.
- The effects of the proposed budget-neutral changes to the tier comorbidities, CMGs, motor score index, and relative weights, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The effects of the proposed adoption of new CBSAs based on the new geographic area definitions announced by OMB in June 2003.
- The effects of the proposed implementation of a budget-neutral teaching status adjustment, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The effects of the proposed budget-neutral update to the percentage amount by which payments are adjusted for IRFs located in rural areas, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The effects of the proposed budget-neutral update to the formula used to calculate the payment adjustment for IRFs based on the percentage of low-income patients they treat, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The effects of the proposed change to the outlier loss threshold amount to maintain total estimated outlier payments at 3 percent of total estimated payments to IRFs in FY 2006, consistent with section 1886(j)(4) of the Act.
- The total change in payments based on the proposed FY 2006 policies relative to payments based on FY 2005 policies.

To illustrate the impacts of the proposed FY 2006 changes, our analysis begins with a FY 2005 baseline simulation model using: IRF charges inflated to FY 2005 using the market basket; the FY 2005 PRICER; the estimated percent of outlier payments in FY 2005; the FY 2005 CMG GROUPER (version 1.22); the MSA designations for IRFs based on OMB's MSA definitions prior to June 2003; the FY 2005 wage index; the FY 2005 labor-market share; the FY 2005 formula for the LIP adjustment; and the FY 2005 percentage amount of the rural adjustment.

Each proposed policy change is then added incrementally to this baseline model, finally arriving at a FY 2006 model incorporating all of the proposed changes to the IRF PPS. This allows us to isolate the effects of each change. Note that, in computing estimated payments per discharge for each of the proposed policy changes, the outlier loss threshold has been adjusted so that estimated outlier payments are 3 percent of total estimated payments.

Our final comparison illustrates the percent change in payments per discharge from FY 2005 to FY 2006. One factor that affects the proposed changes in IRFs' payments from FY 2005 to FY 2006 is that we currently estimate total outlier payments during FY 2005 to be 1.2 percent of total estimated payments. As discussed in the August 7, 2001 final rule (66 FR at 41362), our policy is to set total estimated outlier payments at 3 percent of total estimated payments. Because estimated outlier payments during FY 2005 were below 3 percent of total payments, payments in FY 2006 would increase by an additional 1.8 percent over payments in FY 2005 because of the proposed change in the outlier loss threshold to achieve the 3 percent target.

2. Analysis of Table 13

Table 13 displays the results of our analysis. The table categorizes IRFs by geographic location, including urban or rural location and location with respect to CMS' nine regions of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities by ownership (otherwise called for-profit, non-profit, and government), and by teaching status. The top row of the table shows the overall impact on the 1,188 IRFs included in the analysis.

The next twelve rows of Table 13 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership: all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, by type of ownership, and rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 998 IRFs located in urban areas included in our analysis. Among these, there are 802 IRF units of hospitals located in urban areas and 196 freestanding IRF hospitals located in urban areas. There are 190 IRFs located in rural areas included in our analysis. Among these, there are 169 IRF units of hospitals located in rural areas and 21 freestanding IRF hospitals located in rural areas. There are 354 for-profit IRFs. Among these, there are 295 IRFs in urban areas and 59 IRFs in rural areas. There are 708 non-profit IRFs. Among these, there are 603 urban IRFs and 105 rural IRFs. There are 126 government owned IRFs. Among these, there are 100 urban IRFs and 26 rural IRFs.

The following three parts of Table 13 show IRFs grouped by their geographic location within a region, and the last part groups IRFs by teaching status. First, IRFs located in urban areas are categorized with respect to their location within a particular one of nine geographic regions. Second, IRFs located in rural areas are categorized with respect to their location within a particular one of the nine CMS regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. Finally, IRFs are grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to ADC ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent.

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Table 13 - Projected Impact of FY 2006 Proposed Refinements to the IRF PPS

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	CBSA Wage Index and Labor-share (4)	Outlier (5)	Market Basket (6)	New CMG, New Tiers, and Motor Score (7)	Rural Adjust. (8)	New LIP Adjust. (9)	Teach. Status Adjust. (10)	1.9% Reduct. (11)	Total % Change (12)
Total	1,188	461,738	0.0%	1.8%	3.1%	0.0%	0.0%	0.0%	0.0%	-1.9%	2.9%
Urban unit	802	261,229	0.1%	2.4%	3.1%	0.9%	-0.3%	0.1%	0.6%	-1.9%	5.0%
Rural unit	169	34,664	-1.8%	3.2%	3.1%	1.7%	3.4%	-0.1%	-1.0%	-1.9%	6.5%
Urban hospital	196	158,968	0.3%	0.3%	3.1%	-1.8%	-0.3%	-0.1%	-0.6%	-1.9%	-1.1%
Rural hospital	21	6,877	-1.6%	7.0%	3.1%	-0.7%	3.5%	0.0%	-1.2%	-1.9%	8.1%
Urban For-Profit	295	154,526	0.4%	0.5%	3.1%	-1.9%	-0.3%	-0.1%	-0.9%	-1.9%	-1.1%
Rural For-Profit	59	11,952	-2.8%	3.8%	3.1%	0.3%	3.4%	0.2%	-1.2%	-1.9%	4.7%
Urban Non-Profit	603	237,384	0.0%	2.2%	3.1%	1.0%	-0.3%	0.0%	0.6%	-1.9%	4.6%
Rural Non-Profit	105	23,793	-1.2%	4.2%	3.1%	1.7%	3.4%	-0.3%	-1.0%	-1.9%	8.0%
Urban Government	100	28,287	-0.2%	2.5%	3.1%	0.6%	-0.3%	0.5%	2.1%	-1.9%	6.5%
Rural Government	26	5,796	-1.7%	2.7%	3.1%	1.4%	3.3%	0.3%	-1.2%	-1.9%	6.0%
Urban	998	420,197	0.2%	1.6%	3.1%	-0.1%	-0.3%	0.0%	0.1%	-1.9%	2.6%
Rural	190	41,541	-1.8%	3.9%	3.1%	1.2%	3.4%	-0.1%	-1.1%	-1.9%	6.8%
Urban by region											

Table 13 - Projected Impact of FY 2006 Proposed Refinements to the IRF PPS

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	CBSA Wage Index and Labor-share (4)	Outlier (5)	Market Basket (6)	New CMG, New Tiers, and Motor Score (7)	Rural Adjust. (8)	New LIP Adjust. (9)	Teach. Status Adjust. (10)	1.9% Reduct. (11)	Total % Change (12)
New England	35	20,612	-0.7%	1.6%	3.1%	-0.7%	-0.3%	-0.3%	-0.7%	-1.9%	-0.1%
Middle Atlantic	156	76,962	-0.4%	2.1%	3.1%	1.1%	-0.3%	0.0%	2.0%	-1.9%	5.6%
South Atlantic	124	73,677	0.6%	0.5%	3.1%	-0.5%	-0.3%	0.0%	-0.3%	-1.9%	1.0%
East North Central	189	69,315	0.1%	2.3%	3.1%	1.2%	-0.3%	-0.2%	0.1%	-1.9%	4.3%
East South Central	54	30,473	0.3%	0.0%	3.1%	-1.4%	-0.3%	0.1%	-0.5%	-1.9%	-0.7%
West North Central	71	22,217	-0.1%	2.2%	3.1%	0.6%	-0.3%	-0.1%	0.2%	-1.9%	3.7%
West South Central	184	76,088	0.5%	1.8%	3.1%	-0.7%	-0.3%	-0.1%	-0.6%	-1.9%	1.5%
Mountain	69	24,287	0.0%	1.2%	3.1%	-2.2%	-0.3%	-0.2%	-0.6%	-1.9%	-1.0%
Pacific	116	26,566	0.8%	2.3%	3.1%	-0.8%	-0.3%	1.1%	0.1%	-1.9%	4.4%
Rural by region											
New England	4	924	0.4%	2.2%	3.1%	1.7%	3.2%	-0.4%	-1.1%	-1.9%	7.3%
Middle Atlantic	19	5,377	-0.8%	8.3%	3.1%	1.5%	3.6%	-0.4%	-1.2%	-1.9%	12.3%
South Atlantic	22	5,440	-1.9%	2.6%	3.1%	1.2%	3.4%	0.2%	-1.2%	-1.9%	5.4%
East North Central	28	5,618	-1.2%	3.1%	3.1%	1.9%	3.3%	-0.5%	-1.1%	-1.9%	6.6%

Table 13 - Projected Impact of FY 2006 Proposed Refinements to the IRF PPS

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	CBSA Wage Index and Labor-share (4)	Outlier (5)	Market Basket (6)	New CMG, New Tiers, and Motor Score (7)	Rural Adjust. (8)	New LIP Adjust. (9)	Teach. Status Adjust. (10)	1.9% Reduct. (11)	Total % Change (12)
East South Central	20	5,362	-2.1%	2.2%	3.1%	1.1%	3.5%	0.3%	-0.9%	-1.9%	5.3%
West North Central	30	5,351	-1.4%	2.4%	3.1%	2.7%	3.3%	-0.2%	-0.7%	-1.9%	7.2%
West South Central	54	12,016	-2.5%	4.3%	3.1%	0.4%	3.4%	0.1%	-1.2%	-1.9%	5.6%
Mountain	9	902	-5.7%	9.5%	3.1%	2.6%	3.0%	-0.5%	-1.0%	-1.9%	8.7%
Pacific	4	551	1.7%	2.8%	3.1%	-2.7%	3.0%	-0.9%	-1.0%	-1.9%	3.9%
Teaching Status											
Non-teaching	1,053	400,072	0.0%	1.6%	3.1%	-0.1%	0.1%	-0.1%	-1.1%	-1.9%	1.5%
Resident to ADC less than 10%	71	39,888	0.3%	2.5%	3.1%	0.3%	-0.3%	0.2%	2.6%	-1.9%	7.0%
Resident to ADC 10%-19%	42	17,793	-1.2%	3.0%	3.1%	0.4%	-0.3%	1.2%	11.0%	-1.9%	15.8%
Resident to ADC greater than 19%	22	3,985	-0.1%	4.3%	3.1%	0.0%	-0.3%	1.2%	24.3%	-1.9%	32.1%

3. Impact of the Proposed Market Basket Update to the IRF PPS Payment Rates (Using the RPL Market Basket) (Column 6, Table 13)

In column 6 of Table 13, we present the effects of the proposed market basket update to the IRF PPS payment rates, as discussed in section III.B.1 of this proposed rule. Section 1886(j)(3)(A)(i) of the Act requires us annually to update the per discharge prospective payment rate for IRFs by an increase factor specified by the Secretary and based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made to IRFs, as specified in section 1886(j)(3)(C) of the Act.

As discussed in detail in section III.B.1 of this proposed rule, we are proposing to use a new market basket that reflects the operating and capital cost structures of inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, referred to as the rehabilitation hospital, psychiatric hospital, and long-term care hospital (RPL) market basket. The proposed FY 2006 update for IRF PPS payments using the proposed FY 2002-based RPL market basket and the Global Insight's 4th quarter 2004 forecast would be 3.1 percent.

In the aggregate, and across all hospital groups, the proposed update would result in a 3.1 percent increase in overall payments to IRFs.

4. Impact of Updating the Budget-Neutral Labor-Related Share and MSA-Based Wage Index Adjustment (Column 4, Table 14)

In column 4 of Table 14, we present the effects of a budget-neutral update to the labor-related share and the wage index adjustment (using the geographic area definitions developed by OMB before June 2003), as discussed in section III.B.2 of this proposed rule. Since we are not proposing to use the MSA labor market definitions, table 14 is for reference purposes only.

Section 1886(j)(6) of the Act requires us annually to adjust the proportion of rehabilitation facilities' costs that are attributable to wages and wage-related costs, of the prospective payment rates under the IRF PPS for area differences in wage levels by a factor reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. This section of the Act also requires any such adjustments to be made in a budget-neutral manner.

In accordance with section 1886(j)(6) of the Act, we are proposing to update the labor-related share and adopt the wage index adjustment based on CBSA designations in a budget neutral manner. However, if we do not adopt the CBSA-based designations, this would not change aggregated payments to IRF as indicated in the first row of column 4 in Table 14. If we only update the MSA-based wage index and labor-related share, there would be small distributional effects among different categories of IRFs. For example, rural IRFs would experience a 1.0 percent decrease while urban facilities would experience a 0.1 percent increase in payments based on the RLP labor-related share and MSA-based wage index. Rural IRFs in the East South Central region would experience the largest decrease of 1.8 percent based on the proposed FY 2006 labor-related share and MSA-based wage index. Urban IRFs in the Pacific region would experience the largest increase in payments of 0.8 percent.

Table 14 -Impact of FY 2006 MSA-based Wage Index to the IRF PPS Without Refinements, For Reference Purposes Only

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	MSA Wage Index and Labor-Share (4)	Outlier Impact (5)	Market Basket (6)	Outlier, Market Basket, Labor-Share, MSA Wage Index Change (7)
Total	1,188	461,738	0.0%	1.8%	3.1%	4.9%
Urban unit	791	258,797	0.0%	2.5%	3.1%	5.7%
Rural unit	180	37,096	-0.9%	1.8%	3.1%	4.0%
Urban hospital	193	156,575	0.3%	0.7%	3.1%	4.1%
Rural hospital	24	9,270	-1.3%	1.0%	3.1%	2.8%
Urban For-Profit	292	151,066	0.3%	0.9%	3.1%	4.4%
Rural For-Profit	62	15,412	-1.2%	1.1%	3.1%	2.9%
Urban Non-Profit	596	236,700	0.0%	2.2%	3.1%	5.4%
Rural Non-Profit	112	24,477	-0.8%	1.9%	3.1%	4.3%

Table 14 -Impact of FY 2006 MSA-based Wage Index to the IRF PPS Without Refinements, For Reference Purposes Only

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	MSA Wage Index and Labor-Share (4)	Outlier Impact (5)	Market Basket (6)	Outlier, Market Basket, Labor-Share, MSA Wage Index Change (7)
Urban Government	96	27,606	-0.2%	2.8%	3.1%	5.8%
Rural Government	30	6,477	-1.2%	1.9%	3.1%	3.8%
Urban	984	415,372	0.1%	1.8%	3.1%	5.1%
Rural	204	46,366	-1.0%	1.6%	3.1%	3.7%
Urban by region						
New England	35	20,612	0.1%	1.3%	3.1%	4.5%
Middle Atlantic	155	78,468	-0.5%	2.0%	3.1%	4.6%
South Atlantic	119	70,114	0.3%	1.3%	3.1%	4.8%
East North Central	186	68,742	0.1%	2.3%	3.1%	5.6%
East South Central	52	28,846	0.3%	1.0%	3.1%	4.4%

Table 14 -Impact of FY 2006 MSA-based Wage Index to the IRF PPS Without Refinements, For Reference Purposes Only

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	MSA Wage Index and Labor-Share (4)	Outlier Impact (5)	Market Basket (6)	Outlier, Market Basket, Labor-Share, MSA Wage Index Change (7)
West North Central	69	21,916	0.0%	2.2%	3.1%	5.3%
West South Central	187	76,630	0.4%	1.9%	3.1%	5.5%
Mountain	67	23,735	-0.5%	1.4%	3.1%	4.1%
Pacific	114	26,309	0.8%	2.1%	3.1%	6.1%
Rural by region						
New England	4	924	0.4%	2.1%	3.1%	5.7%
Middle Atlantic	20	3,871	-1.1%	0.8%	3.1%	2.9%
South Atlantic	27	9,003	-0.6%	1.0%	3.1%	3.5%
East North Central	31	6,191	-0.8%	2.4%	3.1%	4.8%
East South Central	22	6,989	-1.8%	0.8%	3.1%	2.0%

Table 14 -Impact of FY 2006 MSA-based Wage Index to the IRF PPS Without Refinements, For Reference Purposes Only

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	MSA Wage Index and Labor-Share (4)	Outlier Impact (5)	Market Basket (6)	Outlier, Market Basket, Labor-Share, MSA Wage Index Change (7)
West North Central	32	5,652	-1.1%	2.2%	3.1%	4.1%
West South Central	51	11,474	-1.1%	1.6%	3.1%	3.6%
Mountain	11	1,454	-0.1%	4.2%	3.1%	7.4%
Pacific	6	808	-0.1%	4.3%	3.1%	7.5%
Teaching Status						
Non-teaching	1,053	400,072	0.0%	1.6%	3.1%	4.8%
Resident to ADC less than 10%	71	39,888	0.4%	2.3%	3.1%	5.9%
Resident to ADC 10%-19%	42	17,793	-0.6%	2.7%	3.1%	5.2%
Resident to ADC greater than 19%	22	3,985	0.0%	4.1%	3.1%	7.3%

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5. Impact of the Proposed 1.9 Percent Decrease in the Standard Payment Amount to Account for Coding Changes (Column 11, Table 13)

In column 11 of Table 13, we present the effects of the proposed decrease in the standard payment amount to account for the increase in aggregate payments due to changes in coding that do not reflect real changes in case mix, as discussed in section III.A of this proposed rule. Section 1886(j)(2)(C)(ii) of the Act requires us to adjust the per discharge PPS payment rate to eliminate the effect of coding or classification changes that do not reflect real changes in case mix if we determine that such changes result in a change in aggregate payments under the classification system.

In the aggregate, and across all hospital groups, the proposed update would result in a 1.9 percent decrease in overall payments to IRFs. Thus, we estimate that the 1.9 percent reduction in the standard payment amount would result in a cost savings to the Medicare program of approximately $120 million.

6. Impact of the Proposed Changes to the CMG Reclassifications and Recalibration of Relative Weights (Column 7, Table 13)

In column 7 of Table 13, we present the effects of the proposed changes to the tier comorbidities, the CMGs, the motor score index, and the proposed recalibration of the relative weights, as discussed in section II.A of this proposed rule. Section 1886(j)(2)(C)(i) of the Act requires us to adjust from time to time the classifications and weighting factors as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment under the IRF PPS is made, and any other factors which may affect the relative use of resources.

As described in section II.A.3 of this proposed rule, we are proposing to update the tier comorbidities to remove condition codes from the list that we believe no longer merit additional payments, move dialysis patients to tier one to increase payments for these patients, and to align payments with the comorbidity conditions according to their effects on the relative costliness of patients. We are also proposing to update the CMGs and the relative weights for the CMGs so that they better reflect the relative costliness of different types of IRF patients. We are also proposing to replace the current motor score index with a weighted motor score index that better estimates the relative costliness of IRF patients. Finally, we are proposing to change the coding of patients with missing information for the transfer to toilet item in the motor score index from 1 to 2.

To assess the impact of these proposed changes, we compared aggregate payments using the FY 2005 CMG relative weights (GROUPER version 1.22) to aggregate payments using the proposed FY 2006 CMG relative weights (GROUPER version 1.30). We note that, under the authority in section 1886(j)(2)(C)(i) of the Act and consistent with our rationale as described in section II.B.4 of this proposed rule, we have applied a budget neutrality factor to ensure that the overall payment impact of the proposed CMG changes is budget neutral (that is, in order that total estimated aggregate payments for FY 2006 with the change are equal to total estimated aggregate payment for FY 2006 without the change). Because we found that the proposed relative weights we would use for calculating the FY 2006 payment rates are slightly higher, on average, than the relative weights we are currently using, and that the effect of this would be to increase aggregate payments, the proposed budget neutrality factor for the CMG and tier changes lowers the standard payment amount somewhat. Because the lower standard payment amount is balanced by the higher average weights, the effect is no change in overall payments to IRFs. However, the distribution of payments among facilities is affected, with some facilities receiving higher payments and some facilities receiving lower payments as a result of the tier and CMG changes, as shown in column 7 of Table 13.

Although, in the aggregate, these proposed changes would not change overall payments to IRFs, as shown in the zero impact in the first row of column 7, there are distributional effects of these changes. On average, the impacts of these proposed changes on any particular group of IRFs are very small, with urban IRFs experiencing a 0.1 percent decrease and rural IRFs experiencing a 1.2 percent increase in aggregate payments. The largest impacts are a 2.7 percent increase among rural IRFs in the West North Central region and a 2.7 percent decrease among rural IRFs in the Pacific region.

7. Impact of the Proposed Changes to New Labor Market Areas (Column 4, Table 13)

In accordance with the broad discretion under section 1886(j)(6) of the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by OMB as discussed in section III.B.2 of this proposed rule. On June 6, 2003, OMB announced new Core-Based Statistical Areas (CBSAs), comprised of MSAs and the new Micropolitan Statistical Areas based on Census 2000 data. We are proposing to adopt the new MSA definitions, consistent with the inpatient prospective payment system, including the 49 new Metropolitan areas designated under the new definitions. We are also proposing to adopt MSA definitions in New England in place of NECMAs. We are proposing not to adopt the newly defined Micropolitan Statistical Areas for use in the payment system, as Micropolitan Statistical Areas would remain part of the statewide rural areas for purposes of the IRF PPS payments, consistent with payments under the inpatient prospective payment system.

The effects of these proposed changes to the new CBSA-based designations are isolated in column 4 of Table 13 by holding all other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the current MSA designations to a model using the proposed new CBSA designations (for Metropolitan areas only).

Table 15 below compares the shifts in proposed wage index values for IRFs for FY 2006 relative to FY 2005. A small number of IRFs (1.6 percent) would experience an increase of between 5 and 10 percent and 1.5 percent of IRFs would experience an increase of more than 10 percent. A small number of IRFs (2.5 percent) would experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Furthermore, IRFs that would experience decreases in their wage index values of greater than 10 percent would be 0.7 percent.

The following table shows the projected impact for IRFs.

TABLE 15.—PROPOSED IMPACT OF THE PROPOSED FY 2006 CBSA-BASED AREA WAGE INDEX

Percent change in area wage index	Percent of IRFs
Decrease Greater Than 10.0	0.7
Decrease Between 5.0 and 10.0	2.5
Decrease Between 2.0 and 5.0	5.7
Decrease Between 0 and 2.0	25.6
No Change	37.2
Increase Between 0 and 2.0	22.1
Increase Between 2.0 and 5.0	3.3
Increase Between 5.0 and 10.0	1.6
Increase Greater Than 10.0	1.5
Total [1]	100.0

[1] May not exactly equal 100 percent due to rounding.

8. Impact of the Proposed Adjustment to the Outlier Threshold Amount (Column 5, Table 13)

We estimate total outlier payments in FY 2005 to be approximately 1.2 percent of total estimated payments, so we are proposing to update the threshold from $11,211 in FY 2005 to $4,911 in FY 2006 in order to set total estimated outlier payments in FY 2006 equal to 3 percent of total estimated payments in FY 2006.

The impact of this proposed change (as shown in column 5 of table 13) is to increase total estimated payments to IRFs by about 1.8 percent.

The effect on payments to rural IRFs would be to increase payments by 3.9 percent, and the effect on payments to urban IRFs would be to increase payments by 1.6 percent. The largest effect would be a 9.5 percent increase in payments to rural IRFs in the Mountain region, and the smallest effect would be

no change in payments for urban IRFs located in the East South Central region.

9. Impact of the Proposed Budget-Neutral Teaching Status Adjustment (Column 10, Table 13)

In column 10 of Table 13, we present the effects of the proposed budget-neutral implementation of a teaching status adjustment to the Federal prospective payment rate for IRFs that have teaching programs, as discussed in section III.B.3 of this proposed rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal prospective payment rates for IRFs under the IRF PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under the authority of section 1886 (j)(3)(A)(v) of the Act, we are proposing to apply a budget neutrality factor to ensure that the overall payment impact of the proposed teaching status adjustment is budget neutral (that is, in order that total estimated aggregate payments for FY 2006 with the proposed adjustment would equal total estimated aggregate payments for FY 2006 without the proposed adjustment). Because IRFs with teaching programs would receive additional payments from the implementation of this proposed new teaching status adjustment, the effect of the proposed budget neutrality factor would be to reduce the standard payment amount, therefore reducing payments to IRFs without teaching programs. By design, however, the increased payments to teaching facilities would balance the decreased payments to non-teaching facilities, and total estimated aggregate payments to all IRFs would remain unchanged. Therefore, the first row of column 10 of Table 13 indicates a zero impact in the aggregate. However, the rest of column 10 gives the distributional effects among different types of providers of this change. Some providers' payments increase and some decrease with this change.

On average, the impacts of this proposed change on any particular group of IRFs are very small, with urban IRFs experiencing a 0.1 percent increase and rural IRFs experiencing a 1.1 percent decrease. The largest impacts are a 2.0 percent increase among urban IRFs in the Middle Atlantic region and 1.2 percent decreases among rural IRFs in the Middle Atlantic, South Atlantic, and West South Central regions.

Overall, non-teaching hospitals would experience a 1.1 percent decrease. The largest impacts are a 24.3 percent increase among teaching facilities with intern and resident to ADC ratios greater than 19 percent. Teaching facilities that have intern and resident to ADC ratios greater than or equal to 10 percent and less than or equal to 19 percent would experience an increase of 11 percent. Teaching facilities with resident and intern to ADC ratios less than 10 percent would experience an increase of 2.6 percent.

10. Impact of the Proposed Update to the Rural Adjustment (Column 8, Table 13)

In column 8 of Table 13, we present the effects of the proposed budget-neutral update to the percentage adjustment to the Federal prospective payment rates for IRFs located in rural areas, as discussed in section III.B.4 of this proposed rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal prospective payment rates for IRFs under the IRF PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In accordance with section 1886(j)(3)(A)(v) of the Act, we are proposing to change the rural adjustment percentage, based on FY 2003 data, from 19.14 percent to 24.1 percent.

Because we are proposing to make this proposed update to the rural adjustment in a budget neutral manner under the broad authority conferred by section 1886(j)(3)(A)(v) of the Act, payments to urban facilities would decrease in proportion to the total increase in payments to rural facilities. To accomplish this redistribution of resources between urban and rural facilities, we propose to apply a budget neutrality factor to reduce the standard payment amount. Rural facilities would receive an increase in payments to this amount, and urban facilities would not. Overall, aggregate payments to IRFs would not change, as indicated by the zero impact in the first row of column 8. However, payments would be redistributed among rural and urban IRFs, as indicated by the rest of the column. On average, because there are a relatively small number of rural facilities, the impacts of this proposed change on urban IRFs are relatively small, with all urban IRFs experiencing a 0.3 percent decrease. The impact on rural IRFs is somewhat larger, with rural IRFs experiencing a 3.4 percent increase. The largest impacts are a 3.6 percent increase among rural IRFs in the Middle Atlantic region.

11. Impact of the Proposed Update to the LIP Adjustment (Column 9, Table 13)

In column 9 of Table 13, we present the effects of the proposed budget-neutral update to the adjustment to the Federal prospective payment rates for IRFs according to the percentage of low-income patients they treat, as discussed in section III.B.5 of this proposed rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal prospective payment rates for IRFs under the IRF PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In accordance with section 1886(j)(3)(A)(v) of the Act, we are proposing to change the formula for the LIP adjustment, based on FY 2003 data, to raise the amount of 1 plus the DSH patient percentage to the power of 0.636 instead of the power of 0.4838. Therefore, the formula to calculate the low-income patient or LIP adjustment would be as follows:

(1 + DSH patient percentage) raised to the power of (.636) Where DSH patient percentage =

$$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, NonMedicare Days}}{\text{Total Days}}$$

Because we are proposing to make this proposed update to the LIP adjustment in a budget neutral manner, payments would be redistributed among providers, according to their low-income percentages, but total estimated aggregate payments to facilities would not change. To do this, we propose to apply a budget neutrality factor that lowers the standard payment amount in proportion to the amount of payment increase that is attributable to the increased LIP adjustment payments. This would result in no change to aggregate payments, which is reflected in the zero impact shown in the first row of column 9 of Table 13. The remaining rows of the column show the

impacts on different categories of providers. On average, the impacts of this proposed change on any particular group of IRFs are small, with urban IRFs experiencing no change in aggregate payments and rural IRFs experiencing a 0.1 percent decrease in aggregate payments. The largest impacts are a 1.2 percent increase among IRFs with 10 percent or higher intern and resident to ADC ratios and 0.9 percent decrease among rural IRFs in the Pacific region.

12. All Proposed Changes (Column 12, Table 13)

Column 12 of Table 13 compares our estimates of the proposed payments per discharge, incorporating all proposed changes reflected in this proposed rule for FY 2006, to our estimates of payments per discharge in FY 2005 (without these proposed changes). This column includes all of the proposed policy changes.

Column 12 reflects all FY 2006 proposed changes relative to FY 2005, shown in columns 4 though 11. The average increase for all IRFs is approximately 2.9 percent. This increase includes the effects of the proposed 3.1 percent market basket update. It also reflects the 1.8 percentage point difference between the estimated outlier payments in FY 2005 (1.2 percent of total estimated payments) and the proposed estimate of the percentage of outlier payments in FY 2006 (3 percent), as described in the introduction to the Addendum to this proposed rule. As a result, payments per discharge are estimated to be 1.8 percent lower in FY 2005 than they would have been had the 3 percent target outlier payment percentage been met, resulting in a 1.8 percent greater increase in total FY 2006 payments than would otherwise have occurred.

It also includes the impact of the proposed one-time 1.9 percent reduction in the standard payment conversion factor to account for changes in coding that increased payments to IRFs. Because we propose to make the remainder of the proposed changes outlined in this proposed rule in a budget-neutral manner, they do not affect total IRF payments in the aggregate. However, as described in more detail in each section, they do affect the distribution of payments among providers.

There might also be interactive effects among the various proposed factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 12 may not equal the sum of the proposed changes described above.

The proposed overall change in payments per discharge for IRFs in FY 2006 would increase by 2.9 percent, as reflected in column 12 of Table 13. IRFs in urban areas would experience a 2.6 percent increase in payments per discharge compared with FY 2005. IRFs in rural areas, meanwhile, would experience a 6.8 percent increase. Rehabilitation units in urban areas would experience a 5 percent increase in payments per discharge, while freestanding rehabilitation hospitals in urban areas would experience a 1.1 percent decrease in payments per discharge. Rehabilitation units in rural areas would experience a 6.5 percent increase in payments per discharge, while freestanding rehabilitation hospitals in rural areas would experience a 8.1 percent increase in payments per discharge.

Overall, the largest payment increase would be 32.1 percent among teaching IRFs with an intern and resident to ADC ratio greater than 19 percent and 15.8 percent among teaching IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent. This is largely due to the proposed teaching status adjustment. Other than for teaching IRFs, the largest payment increase would be 12.3 percent among rural IRFs located in the Middle Atlantic region. This is due largely to the change in the proposed CBSA-based designation from urban to rural, whereby the number of cases in the rural Middle Atlantic Region that would receive the proposed new rural adjustment of 24.1 percent would increase. The only overall decreases in payments would occur among all urban freestanding IRFs and urban IRFs located in the New England, East South Central, and Mountain census regions. The largest of these overall payment decreases would be 1.3 percent among all urban freestanding hospitals. This is due largely to the proposed change in the CBSA-based designation from rural to urban. For non-profit IRFs, we found that rural non-profit facilities would receive the largest payment increase of 8 percent. Conversely, for-profit urban facilities would experience a 1.1 percent overall decrease.

13. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 16 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed changes presented in this proposed rule based on the data for 1,188 IRFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IRFs).

TABLE 16.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2005 TO FY 2006 (IN MILLIONS)

Category	Transfers
Annualized Monetized Transfers.	$180
From Whom To Whom?	Federal Government To IRF Medicare Providers.

List of Subjects in 42 CFR Part 412

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

2. Section 412.602 is amended by revising the definitions of ''Rural area'' and ''Urban area'' to read as follows:

§ 412.602 Definitions.

* * * * *

Rural area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii). For discharges occurring on or after October 1, 2005, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

* * * * *

Urban area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(ii). For discharges occurring on or after October 1, 2005,

urban area means an area as defined in § 412.64(b)(1)(ii)(A) and § 412.64(b)(1)(ii)(B).

§ 412.622 [Amended]

3. Section 412.622 is amended by—

A. In paragraph (b)(1), removing the cross references ''§§ 413.85 and 413.86 of this chapter'' and adding in their place ''§ 413.75 and § 413.85 of this chapter''.

B. In paragraph (b)(2)(i), removing the cross reference to ''§ 413.80 of this chapter'' and adding in its place ''§ 413.89 of this chapter''.

4. Section 412.624 is amended by—

a. In paragraph (d)(1), removing the cross reference to ''paragraph (e)(4)'' and adding in its place ''paragraph (e)(5)''.

b. Adding a new paragraph (d)(4).

c. Redesignating paragraphs (e)(4) and (e)(5) as paragraphs (e)(5) and (e)(6).

d. Adding a new paragraph (e)(4).

e. Revising newly redesignated paragraph (e)(5).

f. Revising newly redesignated paragraph (e)(6).

g. In paragraph (f)(2)(v), removing the cross references to ''paragraphs (e)(1), (e)(2), and (e)(3) of this section'' and adding in their place ''paragraphs (e)(1), (e)(2), (e)(3), and (e)(4) of this section''.

The revisions and additions read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(d) * * *

(4) *Payment adjustment for Federal fiscal year 2006 and subsequent Federal fiscal years.* CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (e)(3), and (e)(4), of this section, and to any revision specified in § 412.620(c).

(e) * * *

(4) *Adjustments for teaching hospitals.* For discharges on or after October 1, 2005, CMS adjusts the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions. This adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report.

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i), except that national averages will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m).

(6) *Adjustments related to the patient assessment instrument.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made, as specified under § 412.614(d), if the transmission of data from a patient assessment instrument is late.

* * * * *

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

Dated: April 14, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 4, 2005.

Michael O. Leavitt,

Secretary.

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble to this proposed rule. The tables presented below are as follows:

Table 1A.—FY 2006 IRF PPS MSA Labor Market Area Designations for Urban Areas for the purposes of comparing Wage Index values with Table 2A.

Table 1B.—FY 2006 IRF PPS MSA Labor Market Area Designations for Rural Areas for the purposes of comparing Wage Index values with Table 2B.

Table 2A.—Proposed Inpatient Rehabilitation Facility (IRF) wage index for urban areas based on proposed CBSA labor market areas for discharges occurring on or after October 1, 2005.

Table 2B.—Proposed Inpatient Rehabilitation Facility (IRF) wage index based on proposed CBSA labor market areas for rural areas for discharges occurring on or after October 1, 2005.

Table 3—Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation; and Proposed New CBSA-based Labor Market Area Designation.

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
0040	Abilene, TX	0.8009
	Taylor, TX.	
0060	Aguadilla, PR	0.4294
	Aguada, PR.	
	Aguadilla, PR.	
	Moca, PR.	
0080	Akron, OH	0.9055
	Portage, OH.	
	Summit, OH.	
0120	Albany, GA	1.1266
	Dougherty, GA.	
	Lee, GA.	
0160	Albany-Schenectady-Troy, NY	0.8570
	Albany, NY.	
	Montgomery, NY.	
	Rensselaer, NY.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Saratoga, NY.	
	Schenectady, NY.	
	Schoharie, NY.	
0200	Albuquerque, NM	1.0485
	Bernalillo, NM.	
	Sandoval, NM.	
	Valencia, NM.	
0220	Alexandria, LA	0.8171
	Rapides, LA.	
0240	Allentown-Bethlehem-Easton, PA	0.9536
	Carbon, PA.	
	Lehigh, PA.	
	Northampton, PA.	
0280	Altoona, PA	0.8462
	Blair, PA.	
0320	Amarillo, TX	0.9178
	Potter, TX.	
	Randall, TX.	
0380	Anchorage, AK	1.2109
	Anchorage, AK.	
0440	Ann Arbor, MI	1.0816
	Lenawee, MI.	
	Livingston, MI.	
	Washtenaw, MI.	
0450	Anniston,AL	0.7881
	Calhoun, AL.	
0460	Appleton-Oshkosh-Neenah, WI	0.9115
	Calumet, WI.	
	Outagamie, WI.	
	Winnebago, WI.	
0470	Arecibo, PR	0.3757
	Arecibo, PR.	
	Camuy, PR.	
	Hatillo, PR.	
0480	Asheville, NC	0.9501
	Buncombe, NC.	
	Madison, NC.	
0500	Athens, GA	1.0202
	Clarke, GA.	
	Madison, GA.	
	Oconee, GA.	
0520	Atlanta, GA	0.9971
	Barrow, GA.	
	Bartow, GA.	
	Carroll, GA.	
	Cherokee, GA.	
	Clayton, GA.	
	Cobb, GA.	
	Coweta, GA.	
	De Kalb, GA.	
	Douglas, GA.	
	Fayette, GA.	
	Forsyth, GA.	
	Fulton, GA.	
	Gwinnett, GA.	
	Henry, GA.	
	Newton, GA.	
	Paulding, GA.	
	Pickens, GA.	
	Rockdale, GA.	
	Spalding, GA.	
	Walton, GA.	
0560	Atlantic City-Cape May, NJ	1.0907
	Atlantic City, NJ.	
	Cape May, NJ.	
0580	Auburn-Opelika, AL	0.8215
	Lee, AL.	
0600	Augusta-Aiken, GA-SC	0.9208
	Columbia, GA.	
	McDuffie, GA.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Richmond, GA.	
	Aiken, SC.	
	Edgefield, SC.	
0640	Austin-San Marcos, TX	0.9595
	Bastrop, TX.	
	Caldwell, TX.	
	Hays, TX.	
	Travis, TX.	
	Williamson, TX.	
0680	Bakersfield, CA	1.0036
	Kern, CA.	
0720	Baltimore, MD	0.9907
	Anne Arundel, MD.	
	Baltimore, MD.	
	Baltimore City, MD.	
	Carroll, MD.	
	Harford, MD.	
	Howard, MD.	
	Queen Annes, MD.	
0733	Bangor, ME	0.9955
	Penobscot, ME.	
0743	Barnstable-Yarmouth, MA	1.2335
	Barnstable, MA.	
0760	Baton Rouge, LA	0.8354
	Ascension, LA.	
	East Baton Rouge.	
	Livingston, LA.	
	West Baton Rouge, LA.	
0840	Beaumont-Port Arthur, TX	0.8616
	Hardin, TX.	
	Jefferson, TX.	
	Orange, TX.	
0860	Bellingham, WA	1.1642
	Whatcom, WA.	
0870	Benton Harbor, MI	0.8847
	Berrien, MI.	
0875	Bergen-Passaic, NJ	1.1967
	Bergen, NJ.	
	Passaic, NJ.	
0880	Billings, MT	0.8961
	Yellowstone, MT.	
0920	Biloxi-Gulfport-Pascagoula, MS	0.8649
	Hancock, MS.	
	Harrison, MS.	
	Jackson, MS.	
0960	Binghamton, NY	0.8447
	Broome, NY.	
	Tioga, NY.	
1000	Birmingham, AL	0.9198
	Blount, AL.	
	Jefferson, AL.	
	St. Clair, AL.	
	Shelby, AL.	
1010	Bismarck, ND	0.7505
	Burleigh, ND.	
	Morton, ND.	
1020	Bloomington, IN	0.8587
	Monroe, IN.	
1040	Bloomington-Normal, IL	0.9111
	McLean, IL.	
1080	Boise City, ID	0.9352
	Ada, ID.	
	Canyon, ID.	
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1290
	Bristol, MA.	
	Essex, MA.	
	Middlesex, MA.	
	Norfolk, MA.	
	Plymouth, MA.	
	Suffolk, MA.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Worcester, MA.	
	Hillsborough, NH.	
	Merrimack, NH.	
	Rockingham, NH.	
	Strafford, NH.	
1125	Boulder-Longmont, CO	1.0046
	Boulder, CO.	
1145	Brazoria, TX	0.8524
	Brazoria, TX.	
1150	Bremerton, WA	1.0614
	Kitsap, WA.	
1240	Brownsville-Harlingen-San Benito, TX	1.0125
	Cameron, TX.	
1260	Bryan-College Station, TX	0.9243
	Brazos, TX.	
1280	Buffalo-Niagara Falls, NY	0.9339
	Erie, NY.	
	Niagara, NY.	
1303	Burlington, VT	0.9322
	Chittenden, VT.	
	Franklin, VT.	
	Grand Isle, VT.	
1310	Caguas, PR	0.4061
	Caguas, PR.	
	Cayey, PR.	
	Cidra, PR.	
	Gurabo, PR.	
	San Lorenzo, PR.	
1320	Canton-Massillon, OH	0.8895
	Carroll, OH.	
	Stark, OH.	
1350	Casper, WY	0.9243
	Natrona, WY.	
1360	Cedar Rapids, IA	0.8975
	Linn, IA.	
1400	Champaign-Urbana, IL	0.9527
	Champaign, IL.	
1440	Charleston-North Charleston, SC	0.9420
	Berkeley, SC.	
	Charleston, SC.	
	Dorchester, SC.	
1480	Charleston, WV	0.8876
	Kanawha, WV.	
	Putnam, WV.	
1520	Charlotte-Gastonia-Rock Hill, NC-SC	0.9711
	Cabarrus, NC.	
	Gaston, NC.	
	Lincoln, NC.	
	Mecklenburg, NC.	
	Rowan, NC.	
	Union, NC.	
	York, SC.	
1540	Charlottesville, VA	1.0294
	Albemarle, VA.	
	Charlottesville City, VA.	
	Fluvanna, VA.	
	Greene, VA.	
1560	Chattanooga, TN-GA	0.9207
	Catoosa, GA.	
	Dade, GA.	
	Walker, GA.	
	Hamilton, TN.	
	Marion, TN.	
1580	Cheyenne, WY	0.8980
	Laramie, WY.	
1600	Chicago, IL	1.0851
	Cook, IL.	
	De Kalb, IL.	
	Du Page, IL.	
	Grundy, IL.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Kane, IL.	
	Kendall, IL.	
	Lake, IL.	
	McHenry, IL.	
	Will, IL.	
1620	Chico-Paradise, CA	1.0542
	Butte, CA.	
1640	Cincinnati, OH-KY-IN	0.9595
	Dearborn, IN.	
	Ohio, IN.	
	Boone, KY.	
	Campbell, KY.	
	Gallatin, KY.	
	Grant, KY.	
	Kenton, KY.	
	Pendleton, KY.	
	Brown, OH.	
	Clermont, OH.	
	Hamilton, OH.	
	Warren, OH.	
1660	Clarksville-Hopkinsville, TN-KY	0.8022
	Christian, KY.	
	Montgomery, TN.	
1680	Cleveland-Lorain-Elyria, OH	0.9626
	Ashtabula, OH.	
	Geauga, OH.	
	Cuyahoga, OH.	
	Lake, OH.	
	Lorain, OH.	
	Medina, OH.	
1720	Colorado Springs, CO	0.9792
	El Paso, CO.	
1740	Columbia MO	0.8396
	Boone, MO.	
1760	Columbia, SC	0.9450
	Lexington, SC.	
	Richland, SC.	
1800	Columbus, GA-AL	0.8690
	Russell, AL.	
	Chattanoochee, GA.	
	Harris, GA.	
	Muscogee, GA.	
1840	Columbus, OH	0.9753
	Delaware, OH.	
	Fairfield, OH.	
	Franklin, OH.	
	Licking, OH.	
	Madison, OH.	
	Pickaway, OH.	
1880	Corpus Christi, TX	0.8647
	Nueces, TX.	
	San Patricio, TX.	
1890	Corvallis, OR	1.0545
	Benton, OR.	
1900	Cumberland, MD-WV	0.8662
	Allegany MD.	
	Mineral WV.	
1920	Dallas, TX	1.0054
	Collin, TX.	
	Dallas, TX.	
	Denton, TX.	
	Ellis, TX.	
	Henderson, TX.	
	Hunt, TX.	
	Kaufman, TX.	
	Rockwall, TX.	
1950	Danville, VA	0.8643
	Danville City, VA.	
	Pittsylvania, VA.	
1960	Davenport-Moline-Rock Island, IA-IL	0.8773

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Scott, IA.	
	Henry, IL.	
	Rock Island, IL.	
2000	Dayton-Springfield, OH	0.9231
	Clark, OH.	
	Greene, OH.	
	Miami, OH.	
	Montgomery, OH.	
2020	Daytona Beach, FL	0.8900
	Flagler, FL.	
	Volusia, FL.	
2030	Decatur, AL	0.8894
	Lawrence, AL.	
	Morgan, AL.	
2040	Decatur, IL	0.8122
	Macon, IL.	
2080	Denver, CO	1.0904
	Adams, CO.	
	Arapahoe, CO.	
	Broomfield, CO.	
	Denver, CO.	
	Douglas, CO.	
	Jefferson, CO.	
2120	Des Moines, IA	0.9266
	Dallas, IA.	
	Polk, IA.	
	Warren, IA.	
2160	Detroit, MI	1.0227
	Lapeer, MI.	
	Macomb, MI.	
	Monroe, MI.	
	Oakland, MI.	
	St. Clair, MI.	
	Wayne, MI.	
2180	Dothan, AL	0.7596
	Dale, AL.	
	Houston, AL.	
2190	Dover, DE	0.9825
	Kent, DE.	
2200	Dubuque, IA	0.8748
	Dubuque, IA.	
2240	Duluth-Superior, MN-WI	1.0356
	St. Louis, MN.	
	Douglas, WI.	
2281	Dutchess County, NY	1.1657
	Dutchess, NY.	
2290	Eau Claire, WI	0.9139
	Chippewa, WI.	
	Eau Claire, WI.	
2320	El Paso, TX	0.9181
	El Paso, TX.	
2330	Elkhart-Goshen, IN	0.9278
	Elkhart, IN.	
2335	Elmira, NY	0.8445
	Chemung, NY.	
2340	Enid, OK	0.9001
	Garfield, OK.	
2360	Erie, PA	0.8699
	Erie, PA.	
2400	Eugene-Springfield, OR	1.0940
	Lane, OR.	
2440	Evansville-Henderson, IN-KY	0.8395
	Posey, IN.	
	Vanderburgh, IN.	
	Warrick, IN.	
	Henderson, KY.	
2520	Fargo-Moorhead, ND-MN	0.9114
	Clay, MN.	
	Cass, ND.	
2560	Fayetteville, NC	0.9363

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Cumberland, NC.	
2580	Fayetteville-Springdale-Rogers, AR	0.8636
	Benton, AR.	
	Washington, AR.	
2620	Flagstaff, AZ-UT	1.0611
	Coconino, AZ.	
	Kane, UT.	
2640	Flint, MI	1.1178
	Genesee, MI.	
2650	Florence, AL	0.7883
	Colbert, AL.	
	Lauderdale, AL.	
2655	Florence, SC	0.8960
	Florence, SC.	
2670	Fort Collins-Loveland, CO	1.0218
	Larimer, CO.	
2680	Ft. Lauderdale, FL	1.0165
	Broward, FL.	
2700	Fort Myers-Cape Coral, FL	0.9371
	Lee, FL.	
2710	Fort Pierce-Port St. Lucie, FL	1.0046
	Martin, FL.	
	St. Lucie, FL.	
2720	Fort Smith, AR-OK	0.8303
	Crawford, AR.	
	Sebastian, AR.	
	Sequoyah, OK.	
2750	Fort Walton Beach, FL	0.8786
	Okaloosa, FL.	
2760	Fort Wayne, IN	0.9737
	Adams, IN.	
	Allen, IN.	
	De Kalb, IN.	
	Huntington, IN.	
	Wells, IN.	
	Whitley, IN.	
2800	Forth Worth-Arlington, TX	0.9520
	Hood, TX.	
	Johnson, TX.	
	Parker, TX.	
	Tarrant, TX.	
2840	Fresno, CA	1.0407
	Fresno, CA.	
	Madera, CA.	
2880	Gadsden, AL	0.8049
	Etowah, AL.	
2900	Gainesville, FL	0.9459
	Alachua, FL.	
2920	Galveston-Texas City, TX	0.9403
	Galveston, TX.	
2960	Gary, IN	0.9342
	Lake, IN.	
	Porter, IN.	
2975	Glens Falls, NY	0.8467
	Warren, NY.	
	Washington, NY.	
2980	Goldsboro, NC	0.8778
	Wayne, NC.	
2985	Grand Forks, ND-MN	0.9091
	Polk, MN.	
	Grand Forks, ND.	
2995	Grand Junction, CO	0.9900
	Mesa, CO.	
3000	Grand Rapids-Muskegon-Holland, MI	0.9519
	Allegan, MI.	
	Kent, MI.	
	Muskegon, MI.	
	Ottawa, MI.	
3040	Great Falls, MT	0.8810
	Cascade, MT.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
3060	Greeley, CO	0.9444
	Weld, CO.	
3080	Green Bay, WI	0.9586
	Brown, WI.	
3120	Greensboro-Winston-Salem-High Point, NC	0.9312
	Alamance, NC.	
	Davidson, NC.	
	Davie, NC.	
	Forsyth, NC.	
	Guilford, NC.	
	Randolph, NC.	
	Stokes, NC.	
	Yadkin, NC.	
3150	Greenville, NC	0.9183
	Pitt, NC.	
3160	Greenville-Spartanburg-Anderson, SC	0.9400
	Anderson, SC.	
	Cherokee, SC.	
	Greenville, SC.	
	Pickens, SC.	
	Spartanburg, SC.	
3180	Hagerstown, MD	0.9940
	Washington, MD.	
3200	Hamilton-Middletown, OH	0.9066
	Butler, OH.	
3240	Harrisburg-Lebanon-Carlisle, PA	0.9286
	Cumberland, PA.	
	Dauphin, PA.	
	Lebanon, PA.	
	Perry, PA.	
3283	Hartford, CT	1.1054
	Hartford, CT.	
	Litchfield, CT.	
	Middlesex, CT.	
	Tolland, CT.	
3285	Hattiesburg, MS	0.7362
	Forrest, MS.	
	Lamar, MS.	
3290	Hickory-Morganton-Lenoir, NC	0.9502
	Alexander, NC.	
	Burke, NC.	
	Caldwell, NC.	
	Catawba, NC.	
3320	Honolulu, HI	1.1013
	Honolulu, HI.	
3350	Houma, LA	0.7721
	Lafourche, LA.	
	Terrebonne, LA.	
3360	Houston, TX	1.0117
	Chambers, TX.	
	Fort Bend, TX.	
	Harris, TX.	
	Liberty, TX.	
	Montgomery, TX.	
	Waller, TX.	
3400	Huntington-Ashland, WV-KY-OH	0.9564
	Boyd, KY.	
	Carter, KY.	
	Greenup, KY.	
	Lawrence, OH.	
	Cabell, WV.	
	Wayne, WV.	
3440	Huntsville, AL	0.8851
	Limestone, AL.	
	Madison, AL.	
3480	Indianapolis, IN	1.0039
	Boone, IN.	
	Hamilton, IN.	
	Hancock, IN.	
	Hendricks, IN.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Johnson, IN.	
	Madison, IN.	
	Marion, IN.	
	Morgan, IN.	
	Shelby, IN.	
3500	Iowa City, IA	0.9654
	Johnson, IA.	
3520	Jackson, MI	0.9146
	Jackson, MI.	
3560	Jackson, MS	0.8406
	Hinds, MS.	
	Madison, MS.	
	Rankin, MS.	
3580	Jackson, TN	0.8900
	Chester, TN.	
	Madison, TN.	
3600	Jacksonville, FL	0.9548
	Clay, FL.	
	Duval, FL.	
	Nassau, FL.	
	St. Johns, FL.	
3605	Jacksonville, NC	0.8401
	Onslow, NC.	
3610	Jamestown, NY	0.7589
	Chautaqua, NY.	
3620	Janesville-Beloit, WI	0.9583
	Rock, WI.	
3640	Jersey City, NJ	1.0923
	Hudson, NJ.	
3660	Johnson City-Kingsport-Bristol, TN-VA	0.8202
	Carter, TN.	
	Hawkins, TN.	
	Sullivan, TN.	
	Unicoi, TN.	
	Washington, TN.	
	Bristol City, VA.	
	Scott, VA.	
	Washington, VA.	
3680	Johnstown, PA	0.7980
	Cambria, PA.	
	Somerset, PA.	
3700	Jonesboro, AR	0.8144
	Craighead, AR.	
3710	Joplin, MO	0.8721
	Jasper, MO.	
	Newton, MO.	
3720	Kalamazoo-Battlecreek, MI	1.0350
	Calhoun, MI.	
	Kalamazoo, MI.	
	Van Buren, MI.	
3740	Kankakee, IL	1.0603
	Kankakee, IL.	
3760	Kansas City, KS-MO	0.9641
	Johnson, KS.	
	Leavenworth, KS.	
	Miami, KS.	
	Wyandotte, KS.	
	Cass, MO.	
	Clay, MO.	
	Clinton, MO.	
	Jackson, MO.	
	Lafayette, MO.	
	Platte, MO.	
	Ray, MO.	
3800	Kenosha, WI	0.9772
	Kenosha, WI.	
3810	Killeen-Temple, TX	0.9242
	Bell, TX.	
	Coryell, TX.	
3840	Knoxville, TN	0.8508

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Anderson, TN.	
	Blount, TN.	
	Knox, TN.	
	Loudon, TN.	
	Sevier, TN.	
	Union, TN.	
3850	Kokomo, IN	0.8986
	Howard, IN.	
	Tipton, IN.	
3870	La Crosse, WI-MN	0.9289
	Houston, MN.	
	La Crosse, WI.	
3880	Lafayette, LA	0.8105
	Acadia, LA.	
	Lafayette, LA.	
	St. Landry, LA.	
	St. Martin, LA.	
3920	Lafayette, IN	0.9067
	Clinton, IN.	
	Tippecanoe, IN.	
3960	Lake Charles, LA	0.7972
	Calcasieu, LA.	
3980	Lakeland-Winter Haven, FL	0.8930
	Polk, FL.	
4000	Lancaster, PA	0.9883
	Lancaster, PA.	
4040	Lansing-East Lansing, MI	0.9658
	Clinton, MI.	
	Eaton, MI.	
	Ingham, MI.	
4080	Laredo, TX	0.8747
	Webb, TX.	
4100	Las Cruces, NM	0.8784
	Dona Ana, NM.	
4120	Las Vegas, NV-AZ	1.1121
	Mohave, AZ.	
	Clark, NV.	
	Nye, NV.	
4150	Lawrence, KS	0.8644
	Douglas, KS.	
4200	Lawton, OK	0.8212
	Comanche, OK.	
4243	Lewiston-Auburn, ME	0.9562
	Androscoggin, ME.	
4280	Lexington, KY	0.9219
	Bourbon, KY.	
	Clark, KY.	
	Fayette, KY.	
	Jessamine, KY.	
	Madison, KY.	
	Scott, KY.	
	Woodford, KY.	
4320	Lima, OH	0.9258
	Allen, OH.	
	Auglaize, OH.	
4360	Lincoln, NE	1.0208
	Lancaster, NE.	
4400	Little Rock-North Little, AR	0.8826
	Faulkner, AR.	
	Lonoke, AR.	
	Pulaski, AR.	
	Saline, AR.	
4420	Longview-Marshall, TX	0.8739
	Gregg, TX.	
	Harrison, TX.	
	Upshur, TX.	
4480	Los Angeles-Long Beach, CA	1.1732
	Los Angeles, CA.	
4520	Louisville, KY-IN	0.9162
	Clark, IN.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Floyd, IN.	
	Harrison, IN.	
	Scott, IN.	
	Bullitt, KY.	
	Jefferson, KY.	
	Oldham, KY.	
4600	Lubbock, TX	0.8777
	Lubbock, TX.	
4640	Lynchburg, VA	0.9017
	Amherst, VA.	
	Bedford City, VA.	
	Bedford, VA.	
	Campbell, VA.	
	Lynchburg City, VA.	
4680	Macon, GA	0.9596
	Bibb, GA.	
	Houston, GA.	
	Jones, GA.	
	Peach, GA.	
	Twiggs, GA.	
4720	Madison, WI	1.0395
	Dane, WI.	
4800	Mansfield, OH	0.9105
	Crawford, OH.	
	Richland, OH.	
4840	Mayaguez, PR	0.4769
	Anasco, PR.	
	Cabo Rojo, PR.	
	Hormigueros, PR.	
	Mayaguez, PR.	
	Sabana Grande, PR.	
	San German, PR.	
4880	McAllen-Edinburg-Mission, TX	0.8602
	Hidalgo, TX.	
4890	Medford-Ashland, OR	1.0534
	Jackson, OR.	
4900	Melbourne-Titusville-Palm Bay, FL	0.9633
	Brevard, FL.	
4920	Memphis, TN-AR-MS	0.9234
	Crittenden, AR.	
	De Soto, MS.	
	Fayette, TN.	
	Shelby, TN.	
	Tipton, TN.	
4940	Merced, CA	1.0575
	Merced, CA.	
5000	Miami, FL	0.9870
	Dade, FL.	
5015	Middlesex-Somerset-Hunterdon, NJ	1.1360
	Hunterdon, NJ.	
	Middlesex, NJ.	
	Somerset, NJ.	
5080	Milwaukee-Waukesha, WI	1.0076
	Milwaukee, WI.	
	Ozaukee, WI.	
	Washington, WI.	
	Waukesha, WI.	
5120	Minneapolis-St. Paul, MN-WI	1.1066
	Anoka, MN.	
	Carver, MN.	
	Chisago, MN.	
	Dakota, MN.	
	Hennepin, MN.	
	Isanti, MN.	
	Ramsey, MN.	
	Scott, MN.	
	Sherburne, MN.	
	Washington, MN.	
	Wright, MN.	
	Pierce, WI.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	St. Croix, WI.	
5140	Missoula, MT	0.9618
	Missoula, MT.	
5160	Mobile, AL	0.7932
	Baldwin, AL.	
	Mobile, AL.	
5170	Modesto, CA	1.1966
	Stanislaus, CA.	
5190	Monmouth-Ocean, NJ	1.0888
	Monmouth, NJ.	
	Ocean, NJ.	
5200	Monroe, LA	0.7913
	Ouachita, LA.	
5240	Montgomery, AL	0.8300
	Autauga, AL.	
	Elmore, AL.	
	Montgomery, AL.	
5280	Muncie, IN	0.8580
	Delaware, IN.	
5330	Myrtle Beach, SC	0.9022
	Horry, SC.	
5345	Naples, FL	1.0558
	Collier, FL.	
5360	Nashville, TN	1.0108
	Cheatham, TN.	
	Davidson, TN.	
	Dickson, TN.	
	Robertson, TN.	
	Rutherford, TN.	
	Sumner, TN.	
	Williamson, TN.	
	Wilson, TN.	
5380	Nassau-Suffolk, NY	1.2907
	Nassau, NY.	
	Suffolk, NY.	
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2254
	Fairfield, CT.	
	New Haven, CT.	
5523	New London-Norwich, CT	1.1596
	New London, CT.	
5560	New Orleans, LA	0.9103
	Jefferson, LA.	
	Orleans, LA.	
	Plaquemines, LA.	
	St. Bernard, LA.	
	St. Charles, LA.	
	St. James, LA.	
	St. John The Baptist, LA.	
	St. Tammany, LA.	
5600	New York, NY	1.3586
	Bronx, NY.	
	Kings, NY.	
	New York, NY.	
	Putnam, NY.	
	Queens, NY.	
	Richmond, NY.	
	Rockland, NY.	
	Westchester, NY.	
5640	Newark, NJ	1.1625
	Essex, NJ.	
	Morris, NJ.	
	Sussex, NJ.	
	Union, NJ.	
	Warren, NJ.	
5660	Newburgh, NY-PA	1.1170
	Orange, NY.	
	Pike, PA.	
5720	Norfolk-Virginia Beach-Newport News, VA-NC	0.8894
	Currituck, NC.	
	Chesapeake City, VA.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Gloucester, VA.	
	Hampton City, VA.	
	Isle of Wight, VA.	
	James City, VA.	
	Mathews, VA.	
	Newport News City, VA.	
	Norfolk City, VA.	
	Poquoson City,VA.	
	Portsmouth City, VA.	
	Suffolk City, VA.	
	Virginia Beach City, VA.	
	Williamsburg City, VA.	
	York, VA.	
5775	Oakland, CA	1.5220
	Alameda, CA.	
	Contra Costa, CA.	
5790	Ocala, FL	0.9153
	Marion, FL.	
5800	Odessa-Midland, TX	0.9632
	Ector, TX.	
	Midland, TX.	
5880	Oklahoma City, OK	0.8966
	Canadian, OK.	
	Cleveland, OK.	
	Logan, OK.	
	McClain, OK.	
	Oklahoma, OK.	
	Pottawatomie, OK.	
5910	Olympia, WA	1.1006
	Thurston, WA.	
5920	Omaha, NE-IA	0.9754
	Pottawattamie, IA.	
	Cass, NE.	
	Douglas, NE.	
	Sarpy, NE.	
	Washington, NE.	
5945	Orange County, CA	1.1611
	Orange, CA.	
5960	Orlando, FL	0.9742
	Lake, FL.	
	Orange, FL.	
	Osceola, FL.	
	Seminole, FL.	
5990	Owensboro, KY	0.8434
	Daviess, KY.	
6015	Panama City, FL	0.8124
	Bay, FL.	
6020	Parkersburg-Marietta, WV-OH	0.8288
	Washington, OH.	
	Wood, WV.	
6080	Pensacola, FL	0.8306
	Escambia, FL.	
	Santa Rosa, FL.	
6120	Peoria-Pekin, IL	0.8886
	Peoria, IL.	
	Tazewell, IL.	
	Woodford, IL.	
6160	Philadelphia, PA-NJ	1.0824
	Burlington, NJ.	
	Camden, NJ.	
	Gloucester, NJ.	
	Salem, NJ.	
	Bucks, PA.	
	Chester, PA.	
	Delaware, PA.	
	Montgomery, PA.	
	Philadelphia, PA.	
6200	Phoenix-Mesa, AZ	0.9982
	Maricopa, AZ.	
	Pinal, AZ.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
6240	Pine Bluff, AR	0.8673
	Jefferson, AR.	
6280	Pittsburgh, PA	0.8756
	Allegheny, PA.	
	Beaver, PA.	
	Butler, PA.	
	Fayette, PA.	
	Washington, PA.	
	Westmoreland, PA.	
6323	Pittsfield, MA	1.0439
	Berkshire, MA.	
6340	Pocatello, ID	0.9601
	Bannock, ID.	
6360	Ponce, PR	0.4954
	Guayanilla, PR.	
	Juana Diaz, PR.	
	Penuelas, PR.	
	Ponce, PR.	
	Villalba, PR.	
	Yauco, PR.	
6403	Portland, ME	1.0112
	Cumberland, ME.	
	Sagadahoc, ME.	
	York, ME.	
6440	Portland-Vancouver, OR-WA	1.1403
	Clackamas, OR.	
	Columbia, OR.	
	Multnomah, OR.	
	Washington, OR.	
	Yamhill, OR.	
	Clark, WA.	
6483	Providence-Warwick-Pawtucket, RI	1.1061
	Bristol, RI.	
	Kent, RI.	
	Newport, RI.	
	Providence, RI.	
	Washington, RI.	
6520	Provo-Orem, UT	0.9613
	Utah, UT.	
6560	Pueblo, CO	0.8752
	Pueblo, CO.	
6580	Punta Gorda, FL	0.9441
	Charlotte, FL.	
6600	Racine, WI	0.9045
	Racine, WI.	
6640	Raleigh-Durham-Chapel Hill, NC	1.0258
	Chatham, NC.	
	Durham, NC.	
	Franklin, NC.	
	Johnston, NC.	
	Orange, NC.	
	Wake, NC.	
6660	Rapid City, SD	0.8912
	Pennington, SD.	
6680	Reading, PA	0.9215
	Berks, PA.	
6690	Redding, CA	1.1835
	Shasta, CA.	
6720	Reno, NV	1.0456
	Washoe, NV.	
6740	Richland-Kennewick-Pasco, WA	1.0520
	Benton, WA.	
	Franklin, WA.	
6760	Richmond-Petersburg, VA	0.9397
	Charles City County, VA.	
	Chesterfield, VA.	
	Colonial Heights City, VA.	
	Dinwiddie, VA.	
	Goochland, VA.	
	Hanover, VA.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Henrico, VA.	
	Hopewell City, VA.	
	New Kent, VA.	
	Petersburg City, VA.	
	Powhatan, VA.	
	Prince George, VA.	
	Richmond City, VA.	
6780	Riverside-San Bernardino, CA	1.0970
	Riverside, CA.	
	San Bernardino, CA.	
6800	Roanoke, VA	0.8428
	Botetourt, VA.	
	Roanoke, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
6820	Rochester, MN	1.1504
	Olmsted, MN.	
6840	Rochester, NY	0.9196
	Genesee, NY.	
	Livingston, NY.	
	Monroe, NY.	
	Ontario, NY.	
	Orleans, NY.	
	Wayne, NY.	
6880	Rockford, IL	0.9626
	Boone, IL.	
	Ogle, IL.	
	Winnebago, IL.	
6895	Rocky Mount, NC	0.8998
	Edgecombe, NC.	
	Nash, NC.	
6920	Sacramento, CA	1.1848
	El Dorado, CA.	
	Placer, CA.	
	Sacramento, CA.	
6960	Saginaw-Bay City-Midland, MI	0.9696
	Bay, MI.	
	Midland, MI.	
	Saginaw, MI.	
6980	St. Cloud, MN	1.0215
	Benton, MN.	
	Stearns, MN.	
7000	St. Joseph, MO	1.0013
	Andrews, MO.	
	Buchanan, MO.	
7040	St. Louis, MO-IL	0.9081
	Clinton, IL.	
	Jersey, IL.	
	Madison, IL.	
	Monroe, IL.	
	St. Clair, IL.	
	Franklin, MO.	
	Jefferson, MO.	
	Lincoln, MO.	
	St. Charles, MO.	
	St. Louis, MO.	
	St. Louis City, MO.	
	Warren, MO.	
	Sullivan City, MO.	
7080	Salem, OR	1.0556
	Marion, OR.	
	Polk, OR.	
7120	Salinas, CA	1.3823
	Monterey, CA.	
7160	Salt Lake City-Ogden, UT	0.9487
	Davis, UT.	
	Salt Lake, UT.	
	Weber, UT.	
7200	San Angelo, TX	0.8167
	Tom Green, TX.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
7240	San Antonio, TX	0.9023
	Bexar, TX.	
	Comal, TX.	
	Guadalupe, TX.	
	Wilson, TX.	
7320	San Diego, CA	1.1267
	San Diego, CA.	
7360	San Francisco, CA	1.4712
	Marin, CA.	
	San Francisco, CA.	
	San Mateo, CA.	
7400	San Jose, CA	1.4744
	Santa Clara, CA.	
7440	San Juan-Bayamon, PR	0.4802
	Aguas Buenas, PR.	
	Barceloneta, PR.	
	Bayamon, PR.	
	Canovanas, PR.	
	Carolina, PR.	
	Catano, PR.	
	Ceiba, PR.	
	Comerio, PR.	
	Corozal, PR.	
	Dorado, PR.	
	Fajardo, PR.	
	Florida, PR.	
	Guaynabo, PR.	
	Humacao, PR.	
	Juncos, PR.	
	Los Piedras, PR.	
	Loiza, PR.	
	Luguillo, PR.	
	Manati, PR.	
	Morovis, PR.	
	Naguabo, PR.	
	Naranjito, PR.	
	Rio Grande, PR.	
	San Juan, PR.	
	Toa Alta, PR.	
	Toa Baja, PR.	
	Trujillo Alto, PR.	
	Vega Alta, PR.	
	Vega Baja, PR.	
	Yabucoa, PR.	
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1118
	San Luis Obispo, CA.	
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0771
	Santa Barbara, CA.	
7485	Santa Cruz-Watsonville, CA	1.4779
	Santa Cruz, CA.	
7490	Santa Fe, NM	1.0590
	Los Alamos, NM.	
	Santa Fe, NM.	
7500	Santa Rosa, CA	1.2961
	Sonoma, CA.	
7510	Sarasota-Bradenton, FL	0.9629
	Manatee, FL.	
	Sarasota, FL.	
7520	Savannah, GA	0.9460
	Bryan, GA.	
	Chatham, GA.	
	Effingham, GA.	
7560	Scranton—Wilkes-Barre—Hazleton, PA	0.8522
	Columbia, PA.	
	Lackawanna, PA.	
	Luzerne, PA.	
	Wyoming, PA.	
7600	Seattle-Bellevue-Everett, WA	1.1479
	Island, WA.	
	King, WA.	

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Snohomish, WA.	
7610	Sharon, PA	0.7881
	Mercer, PA.	
7620	Sheboygan, WI	0.8948
	Sheboygan, WI.	
7640	Sherman-Denison, TX	0.9617
	Grayson, TX.	
7680	Shreveport-Bossier City, LA	0.9111
	Bossier, LA.	
	Caddo, LA.	
	Webster, LA.	
7720	Sioux City, IA-NE	0.9094
	Woodbury, IA.	
	Dakota, NE.	
7760	Sioux Falls, SD	0.9441
	Lincoln, SD.	
	Minnehaha, SD.	
7800	South Bend, IN	0.9447
	St. Joseph, IN.	
7840	Spokane, WA	1.0660
	Spokane, WA.	
7880	Springfield, IL	0.8738
	Menard, IL.	
	Sangamon, IL.	
7920	Springfield, MO	0.8597
	Christian, MO.	
	Greene, MO.	
	Webster, MO.	
8003	Springfield, MA	1.0173
	Hampden, MA.	
	Hampshire, MA.	
8050	State College, PA	0.8461
	Centre, PA.	
8080	Steubenville-Weirton, OH-WV	0.8280
	Jefferson, OH.	
	Brooke, WV.	
	Hancock, WV.	
8120	Stockton-Lodi, CA	1.0564
	San Joaquin, CA.	
8140	Sumter, SC	0.8520
	Sumter, SC.	
8160	Syracuse, NY	0.9394
	Cayuga, NY.	
	Madison, NY.	
	Onondaga, NY.	
	Oswego, NY.	
8200	Tacoma, WA	1.1078
	Pierce, WA.	
8240	Tallahassee, FL	0.8655
	Gadsden, FL.	
	Leon, FL.	
8280	Tampa-St. Petersburg-Clearwater, FL	0.9024
	Hernando, FL.	
	Hillsborough, FL.	
	Pasco, FL.	
	Pinellas, FL.	
8320	Terre Haute, IN	0.8582
	Clay, IN.	
	Vermillion, IN.	
	Vigo, IN.	
8360	Texarkana, AR-Texarkana, TX	0.8413
	Miller, AR.	
	Bowie, TX.	
8400	Toledo, OH	0.9524
	Fulton, OH.	
	Lucas, OH.	
	Wood, OH.	
8440	Topeka, KS	0.8904
	Shawnee, KS.	
8480	Trenton, NJ	1.0276

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Mercer, NJ.	
8520	Tucson, AZ	0.8926
	Pima, AZ.	
8560	Tulsa, OK	0.8729
	Creek, OK.	
	Osage, OK.	
	Rogers, OK.	
	Tulsa, OK.	
	Wagoner, OK.	
8600	Tuscaloosa, AL	0.8440
	Tuscaloosa, AL.	
8640	Tyler, TX	0.9502
	Smith, TX.	
8680	Utica-Rome, NY	0.8295
	Herkimer, NY.	
	Oneida, NY.	
8720	Vallejo-Fairfield-Napa, CA	1.3517
	Napa, CA.	
	Solano, CA.	
8735	Ventura, CA	1.1105
	Ventura, CA.	
8750	Victoria, TX	0.8469
	Victoria, TX.	
8760	Vineland-Millville-Bridgeton, NJ	1.0573
	Cumberland, NJ.	
8780	Visalia-Tulare-Porterville, CA	0.9975
	Tulare, CA.	
8800	Waco, TX	0.8146
	McLennan, TX.	
8840	Washington, DC-MD-VA-WV	1.0971
	District of Columbia, DC.	
	Calvert, MD.	
	Charles, MD.	
	Frederick, MD.	
	Montgomery, MD.	
	Prince Georges, MD.	
	Alexandria City, VA.	
	Arlington, VA.	
	Clarke, VA.	
	Culpepper, VA.	
	Fairfax, VA.	
	Fairfax City, VA.	
	Falls Church City, VA.	
	Fauquier, VA.	
	Fredericksburg City, VA.	
	King George, VA.	
	Loudoun, VA.	
	Manassas City, VA.	
	Manassas Park City, VA.	
	Prince William, VA.	
	Spotsylvania, VA.	
	Stafford, VA.	
	Warren, VA.	
	Berkeley, WV.	
	Jefferson, WV.	
8920	Waterloo-Cedar Falls, IA	0.8633
	Black Hawk, IA.	
8940	Wausau, WI	0.9570
	Marathon, WI.	
8960	West Palm Beach-Boca Raton, FL	1.0362
	Palm Beach, FL.	
9000	Wheeling, OH-WV	0.7449
	Belmont, OH.	
	Marshall, WV.	
	Ohio, WV.	
9040	Wichita, KS	0.9486
	Butler, KS.	
	Harvey, KS.	
	Sedgwick, KS.	
9080	Wichita Falls, TX	0.8395

TABLE 1A.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR URBAN AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2A—Continued

MSA	Urban area (Constituent Counties or County Equivalents)	Wage index
	Archer, TX.	
	Wichita, TX.	
9140	Williamsport, PA	0.8485
	Lycoming, PA.	
9160	Wilmington-Newark, DE-MD	1.1121
	New Castle, DE.	
	Cecil, MD.	
9200	Wilmington, NC	0.9237
	New Hanover, NC.	
	Brunswick, NC.	
9260	Yakima, WA	1.0322
	Yakima, WA.	
9270	Yolo, CA	0.9378
	Yolo, CA.	
9280	York, PA	0.9150
	York, PA.	
9320	Youngstown-Warren, OH	0.9517
	Columbiana, OH.	
	Mahoning, OH.	
	Trumbull, OH.	
9340	Yuba City, CA	1.0363
	Sutter, CA.	
	Yuba, CA.	
9360	Yuma, AZ	0.8871
	Yuma, AZ.	

TABLE 1B.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR RURAL AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2B

Nonurban area	Wage Index
Alabama	0.7637
Alaska	1.1637
Arizona	0.9140
Arkansas	0.7703
California	1.0297
Colorado	0.9368
Connecticut	1.1917
Delaware	0.9503
Florida	0.8721
Georgia	0.8247
Guam	0.9611
Hawaii	1.0522
Idaho	0.8826
Illinois	0.8340
Indiana	0.8736
Iowa	0.8550
Kansas	0.8087
Kentucky	0.7844
Louisiana	0.7290
Maine	0.9039

TABLE 1B.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR RURAL AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2B—Continued

Nonurban area	Wage Index
Maryland	0.9179
Massachusetts	1.0216
Michigan	0.8740
Minnesota	0.9339
Mississippi	0.7583
Missouri	0.7829
Montana	0.8701
Nebraska	0.9035
Nevada	0.9832
New Hampshire	0.9940
New Jersey [1]	.....
New Mexico	0.8529
New York	0.8403
North Carolina	0.8500
North Dakota	0.7743
Ohio	0.8759
Oklahoma	0.7537
Oregon	1.0049

TABLE 1B.—FY 2006 IRF PPS MSA LABOR MARKET AREA DESIGNATIONS FOR RURAL AREAS FOR THE PURPOSES OF COMPARING WAGE INDEX VALUES WITH TABLE 2B—Continued

Nonurban area	Wage Index
Pennsylvania	0.8348
Puerto Rico	0.4047
Rhode Island [1]	.....
South Carolina	0.8640
South Dakota	0.8393
Tennessee	0.7876
Texas	0.7910
Utah	0.8843
Vermont	0.9375
Virginia	0.8479
Virgin Islands	0.7456
Washington	1.0072
West Virginia	0.8083
Wisconsin	0.9498
Wyoming	0.9182

[1] All counties within the State are classified urban.

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005

CBSA code	Urban area (Constituent counties)	Full wage Index
10180	Abilene, TX	0.7850
	Callahan County, TX.	
	Jones County, TX.	
	Taylor County, TX.	
10380	Aguadilla-Isabela-San Sebastián, PR	0.4280
	Aguada Municipio, PR.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Aguadilla Municipio, PR.	
	Aasco Municipio, PR.	
	Isabela Municipio, PR.	
	Lares Municipio, PR.	
	Moca Municipio, PR.	
	Rincín Municipio, PR.	
	San Sebastián Municipio, PR.	
10420	Akron, OH	0.9055
	Portage County, OH.	
	Summit County, OH.	
10500	Albany, GA	1.1266
	Baker County, GA.	
	Dougherty County, GA.	
	Lee County, GA.	
	Terrell County, GA.	
	Worth County, GA.	
10580	Albany-Schenectady-Troy, NY	0.8650
	Albany County, NY.	
	Rensselaer County, NY.	
	Saratoga County, NY.	
	Schenectady County, NY.	
	Schoharie County, NY.	
10740	Albuquerque, NM	1.0485
	Bernalillo County, NM.	
	Sandoval County, NM.	
	Torrance County, NM.	
	Valencia County, NM.	
10780	Alexandria, LA	0.8171
	Grant Parish, LA.	
	Rapides Parish, LA.	
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9501
	Warren County, NJ.	
	Carbon County, PA.	
	Lehigh County, PA.	
	Northampton County, PA.	
11020	Altoona, PA	0.8462
	Blair County, PA.	
11100	Amarillo, TX	0.9178
	Armstrong County, TX.	
	Carson County, TX.	
	Potter County, TX.	
	Randall County, TX.	
11180	Ames, IA	0.9479
	Story County, IA.	
11260	Anchorage, AK	1.2165
	Anchorage Municipality, AK.	
	Matanuska-Susitna Borough, AK.	
11300	Anderson, IN	0.8713
	Madison County, IN.	
11340	Anderson, SC	0.8670
	Anderson County, SC.	
11460	Ann Arbor, MI	1.1022
	Washtenaw County, MI.	
11500	Anniston-Oxford, AL	0.7881
	Calhoun County, AL.	
11540	Appleton, WI	0.9131
	Calumet County, WI.	
	Outagamie County, WI.	
11700	Asheville, NC	0.9191
	Buncombe County, NC.	
	Haywood County, NC.	
	Henderson County, NC.	
	Madison County, NC.	
12020	Athens-Clarke County, GA	1.0202
	Clarke County, GA.	
	Madison County, GA.	
	Oconee County, GA.	
	Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9971
	Barrow County, GA.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Bartow County, GA.	
	Butts County, GA.	
	Carroll County, GA.	
	Cherokee County, GA.	
	Clayton County, GA.	
	Cobb County, GA.	
	Coweta County, GA.	
	Dawson County, GA.	
	DeKalb County, GA.	
	Douglas County, GA.	
	Fayette County, GA.	
	Forsyth County, GA.	
	Fulton County, GA.	
	Gwinnett County, GA.	
	Haralson County, GA.	
	Heard County, GA.	
	Henry County, GA.	
	Jasper County, GA.	
	Lamar County, GA.	
	Meriwether County, GA.	
	Newton County, GA.	
	Paulding County, GA.	
	Pickens County, GA.	
	Pike County, GA.	
	Rockdale County, GA.	
	Spalding County, GA.	
	Walton County, GA.	
12100	Atlantic City, NJ	1.0931
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.8215
	Lee County, AL.	
12260	Augusta-Richmond County, GA-SC	0.9154
	Burke County, GA.	
	Columbia County, GA.	
	McDuffie County, GA.	
	Richmond County, GA.	
	Aiken County, SC.	
	Edgefield County, SC.	
12420	Austin-Round Rock, TX	0.9595
	Bastrop County, TX.	
	Caldwell County, TX.	
	Hays County, TX.	
	Travis County, TX.	
	Williamson County, TX.	
12540	Bakersfield, CA	1.0036
	Kern County, CA.	
12580	Baltimore-Towson, MD	0.9907
	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	0.9955
	Penobscot County, ME.	
12700	Barnstable Town, MA	1.2335
	Barnstable County, MA.	
12940	Baton Rouge, LA	0.8319
	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	0.9366
	Calhoun County, MI.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
13020	Bay City, MI	0.9574
	Bay County, MI.	
13140	Beaumont-Port Arthur, TX	0.8616
	Hardin County, TX.	
	Jefferson County, TX.	
	Orange County, TX.	
13380	Bellingham, WA	1.1642
	Whatcom County, WA.	
13460	Bend, OR	1.0603
	Deschutes County, OR.	
13644	Bethesda-Frederick-Gaithersburg, MD	1.0956
	Frederick County, MD.	
	Montgomery County, MD.	
13740	Billings, MT	0.8961
	Carbon County, MT.	
	Yellowstone County, MT.	
13780	Binghamton, NY	0.8447
	Broome County, NY.	
	Tioga County, NY.	
13820	Birmingham-Hoover, AL	0.9157
	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	0.7505
	Burleigh County, ND.	
	Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA	0.7951
	Giles County, VA.	
	Montgomery County, VA.	
	Pulaski County, VA.	
	Radford City, VA.	
14020	Bloomington, IN	0.8587
	Greene County, IN.	
	Monroe County, IN.	
	Owen County, IN.	
14060	Bloomington-Normal, IL	0.9111
	McLean County, IL.	
14260	Boise City-Nampa, ID	0.9352
	Ada County, ID.	
	Boise County, ID.	
	Canyon County, ID.	
	Gem County, ID.	
	Owyhee County, ID.	
14484	Boston-Quincy, MA	1.1771
	Norfolk County, MA.	
	Plymouth County, MA.	
	Suffolk County, MA.	
14500	Boulder, CO	1.0046
	Boulder County, CO.	
14540	Bowling Green, KY	0.8140
	Edmonson County, KY.	
	Warren County, KY.	
14740	Bremerton-Silverdale, WA	1.0614
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT	1.2835
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX	1.0125
	Cameron County, TX.	
15260	Brunswick, GA	1.1933
	Brantley County, GA.	
	Glynn County, GA.	
	McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY	0.9339
	Erie County, NY.	
	Niagara County, NY.	
15500	Burlington, NC	0.8967

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Alamance County, NC.	
15540	Burlington-South Burlington, VT	0.9322
	Chittenden County, VT.	
	Franklin County, VT.	
	Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA	1.1189
	Middlesex County, MA.	
15804	Camden, NJ	1.0675
	Burlington County, NJ.	
	Camden County, NJ.	
	Gloucester County, NJ.	
15940	Canton-Massillon, OH	0.8895
	Carroll County, OH.	
	Stark County, OH.	
15980	Cape Coral-Fort Myers, FL	0.9371
	Lee County, FL.	
16180	Carson City, NV	1.0352
	Carson City, NV.	
16220	Casper, WY	0.9243
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.8975
	Benton County, IA.	
	Jones County, IA.	
	Linn County, IA.	
16580	Champaign-Urbana, IL	0.9527
	Champaign County, IL.	
	Ford County, IL.	
	Piatt County, IL.	
16620	Charleston, WV	0.8876
	Boone County, WV.	
	Clay County, WV.	
	Kanawha County, WV.	
	Lincoln County, WV.	
	Putnam County, WV.	
16700	Charleston-North Charleston, SC	0.9420
	Berkeley County, SC.	
	Charleston County, SC.	
	Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC-SC	0.9743
	Anson County, NC.	
	Cabarrus County, NC.	
	Gaston County, NC.	
	Mecklenburg County, NC.	
	Union County, NC.	
	York County, SC.	
16820	Charlottesville, VA	1.0294
	Albemarle County, VA.	
	Fluvanna County, VA.	
	Greene County, VA.	
	Nelson County, VA.	
	Charlottesville City, VA.	
16860	Chattanooga, TN-GA	0.9207
	Catoosa County, GA.	
	Dade County, GA.	
	Walker County, GA.	
	Hamilton County, TN.	
	Marion County, TN.	
	Sequatchie County, TN.	
16940	Cheyenne, WY	0.8980
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL	1.0868
	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	1.0542

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Butte County, CA.	
17140	Cincinnati-Middletown, OH-KY-IN	0.9516
	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	0.8022
	Christian County, KY.	
	Trigg County, KY.	
	Montgomery County, TN.	
	Stewart County, TN.	
17420	Cleveland, TN	0.7844
	Bradley County, TN.	
	Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH	0.9650
	Cuyahoga County, OH.	
	Geauga County, OH.	
	Lake County, OH.	
	Lorain County, OH.	
	Medina County, OH.	
17660	Coeur d'Alene, ID	0.9339
	Kootenai County, ID.	
17780	College Station-Bryan, TX	0.9243
	Brazos County, TX.	
	Burleson County, TX.	
	Robertson County, TX.	
17820	Colorado Springs, CO	0.9792
	El Paso County, CO.	
	Teller County, CO.	
17860	Columbia, M	0.8396
	Boone County, MO.	
	Howard County, MO.	
17900	Columbia, SC	0.9392
	Calhoun County, SC.	
	Fairfield County, SC.	
	Kershaw County, SC.	
	Lexington County, SC.	
	Richland County, SC.	
	Saluda County, SC.	
17980	Columbus, GA-AL	0.8690
	Russell County, AL.	
	Chattahoochee County, GA.	
	Harris County, GA.	
	Marion County, GA.	
	Muscogee County, GA.	
18020	Columbus, IN	0.9388
	Bartholomew County, IN.	
18140	Columbus, OH	0.9737
	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	0.8647
	Aransas County, TX.	
	Nueces County, TX.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	San Patricio County, TX.	
18700	Corvallis, OR	1.0545
	Benton County, OR.	
19060	Cumberland, MD-WV	0.8662
	Allegany County, MD.	
	Mineral County, WV.	
19124	Dallas-Plano-Irving, TX	1.0074
	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	0.9558
	Murray County, GA.	
	Whitfield County, GA.	
19180	Danville, IL	0.8392
	Vermilion County, IL.	
19260	Danville, VA	0.8643
	Pittsylvania County, VA.	
	Danville City, VA.	
19340	Davenport-Moline-Rock Island, IA-IL	0.8773
	Henry County, IL.	
	Mercer County, IL.	
	Rock Island County, IL.	
	Scott County, IA.	
19380	Dayton, OH	0.9303
	Greene County, OH.	
	Miami County, OH.	
	Montgomery County, OH.	
	Preble County, OH.	
19460	Decatur, AL	0.8894
	Lawrence County, AL.	
	Morgan County, AL.	
19500	Decatur, IL	0.8122
	Macon County, IL.	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.8898
	Volusia County, FL.	
19740	Denver-Aurora, CO	1.0904
	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, IA	0.9266
	Dallas County, IA.	
	Guthrie County, IA.	
	Madison County, IA.	
	Polk County, IA.	
	Warren County, IA.	
19804	Detroit-Livonia-Dearborn, MI	1.0349
	Wayne County, MI.	
20020	Dothan, AL	0.7537
	Geneva County, AL.	
	Henry County, AL.	
	Houston County, AL.	
20100	Dover, DE	0.9825
	Kent County, DE.	
20220	Dubuque, IA	0.8748
	Dubuque County, IA.	
20260	Duluth, MN-WI	1.0340
	Carlton County, MN.	
	St. Louis County, MN.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Douglas County, WI.	
20500	Durham, NC	1.0363
	Chatham County, NC.	
	Durham County, NC.	
	Orange County, NC.	
	Person County, NC.	
20740	Eau Claire, WI	0.9139
	Chippewa County, WI.	
	Eau Claire County, WI.	
20764	Edison, NJ	1.1136
	Middlesex County, NJ.	
	Monmouth County, NJ.	
	Ocean County, NJ.	
	Somerset County, NJ.	
20940	El Centro, CA	0.8856
	Imperial County, CA.	
21060	Elizabethtown, KY	0.8684
	Hardin County, KY.	
	Larue County, KY.	
21140	Elkhart-Goshen, IN	0.9278
	Elkhart County, IN.	
21300	Elmira, NY	0.8445
	Chemung County, NY.	
21340	El Paso, TX	0.9181
	El Paso County, TX.	
21500	Erie, PA	0.8699
	Erie County, PA.	
21604	Essex County, MA	1.0662
	Essex County, MA.	
21660	Eugene-Springfield, OR	1.0940
	Lane County, OR.	
21780	Evansville, IN-KY	0.8372
	Gibson County, IN.	
	Posey County, IN.	
	Vanderburgh County, IN.	
	Warrick County, IN.	
	Henderson County, KY.	
	Webster County, KY.	
21820	Fairbanks, AK	1.1146
	Fairbanks North Star Borough, AK.	
21940	Fajardo, PR	0.3939
	Ceiba Municipio, PR.	
	Fajardo Municipio, PR.	
	Luquillo Municipio, PR.	
22020	Fargo, ND-MN	0.9114
	Cass County, ND.	
	Clay County, MN.	
22140	Farmington, NM	0.8049
	San Juan County, NM.	
22180	Fayetteville, NC	0.9363
	Cumberland County, NC.	
	Hoke County, NC.	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8636
	Benton County, AR.	
	Madison County, AR.	
	Washington County, AR.	
	McDonald County, MO.	
22380	Flagstaff, AZ	1.0787
	Coconino County, AZ.	
22420	Flint, MI	1.1178
	Genesee County, MI.	
22500	Florence, SC	0.8833
	Darlington County, SC.	
	Florence County, SC.	
22520	Florence-Muscle Shoals, AL	0.7883
	Colbert County, AL.	
	Lauderdale County, AL.	
22540	Fond du Lac, WI	0.9897
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO	1.0218

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0165
	Broward County, FL.	
22900	Fort Smith, AR-OK	0.8283
	Crawford County, AR.	
	Franklin County, AR.	
	Sebastian County, AR.	
	Le Flore County, OK.	
	Sequoyah County, OK.	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8786
	Okaloosa County, FL.	
23060	Fort Wayne, IN	0.9807
	Allen County, IN.	
	Wells County, IN.	
	Whitley County, IN.	
23104	Fort Worth-Arlington, TX	0.9472
	Johnson County, TX.	
	Parker County, TX.	
	Tarrant County, TX.	
	Wise County, TX.	
23420	Fresno, CA	1.0536
	Fresno County, CA.	
23460	Gadsden, AL	0.8049
	Etowah County, AL.	
23540	Gainesville, FL	0.9459
	Alachua County, FL.	
	Gilchrist County, FL.	
23580	Gainesville, GA	0.9557
	Hall County, GA.	
23844	Gary, IN	0.9310
	Jasper County, IN.	
	Lake County, IN.	
	Newton County, IN.	
	Porter County, IN.	
24020	Glens Falls, NY	0.8467
	Warren County, NY.	
	Washington County, NY.	
24140	Goldsboro, NC	0.8778
	Wayne County, NC.	
24220	Grand Forks, ND-MN	0.9091
	Polk County, MN.	
	Grand Forks County, ND.	
24300	Grand Junction, CO	0.9900
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI	0.9420
	Barry County, MI.	
	Ionia County, MI.	
	Kent County, MI.	
	Newaygo County, MI.	
24500	Great Falls, MT	0.8810
	Cascade County, MT.	
24540	Greeley, CO	0.9444
	Weld County, CO.	
24580	Green Bay, WI	0.9590
	Brown County, WI.	
	Kewaunee County, WI.	
	Oconto County, WI.	
24660	Greensboro-High Point, NC	0.9190
	Guilford County, NC.	
	Randolph County, NC.	
	Rockingham County, NC.	
24780	Greenville, NC	0.9183
	Greene County, NC.	
	Pitt County, NC.	
24860	Greenville, SC	0.9557
	Greenville County, SC.	
	Laurens County, SC.	
	Pickens County, SC.	
25020	Guayama, PR	0.4005
	Arroyo Municipio, PR.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Guayama Municipio, PR.	
	Patillas Municipio, PR.	
25060	Gulfport-Biloxi, MS	0.8950
	Hancock County, MS.	
	Harrison County, MS.	
	Stone County, MS.	
25180	Hagerstown-Martinsburg, MD-WV	0.9715
	Washington County, MD.	
	Berkeley County, WV.	
	Morgan County, WV.	
25260	Hanford-Corcoran, CA	0.9296
	Kings County, CA.	
25420	Harrisburg-Carlisle, PA	0.9359
	Cumberland County, PA.	
	Dauphin County, PA.	
	Perry County, PA.	
25500	Harrisonburg, VA	0.9275
	Rockingham County, VA.	
	Harrisonburg City, VA.	
25540	Hartford-West Hartford-East Hartford, CT	1.1054
	Hartford County, CT.	
	Litchfield County, CT.	
	Middlesex County, CT.	
	Tolland County, CT.	
25620	Hattiesburg, MS	0.7362
	Forrest County, MS.	
	Lamar County, MS.	
	Perry County, MS.	
25860	Hickory-Lenoir-Morganton, NC	0.9502
	Alexander County, NC.	
	Burke County, NC.	
	Caldwell County, NC.	
	Catawba County, NC.	
25980	Hinesville-Fort Stewart, GA	0.7715
	Liberty County, GA.	
	Long County, GA.	
26100	Holland-Grand Haven, MI	0.9388
	Ottawa County, MI.	
26180	Honolulu, HI	1.1013
	Honolulu County, HI.	
26300	Hot Springs, AR	0.9249
	Garland County, AR.	
26380	Houma-Bayou Cane-Thibodaux, LA	0.7721
	Lafourche Parish, LA.	
	Terrebonne Parish, LA.	
26420	Houston-Baytown-Sugar Land, TX	0.9973
	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	0.9564
	Boyd County, KY.	
	Greenup County, KY.	
	Lawrence County, OH.	
	Cabell County, WV.	
	Wayne County, WV.	
26620	Huntsville, AL	0.8851
	Limestone County, AL.	
	Madison County, AL.	
26820	Idaho Falls, ID	0.9059
	Bonneville County, ID.	
	Jefferson County, ID.	
26900	Indianapolis, IN	1.0113
	Boone County, IN.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	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	0.9654
	Johnson County, IA.	
	Washington County, IA.	
27060	Ithaca, NY	0.9589
	Tompkins County, NY.	
27100	Jackson, MI	0.9146
	Jackson County, MI.	
27140	Jackson, MS	0.8291
	Copiah County, MS.	
	Hinds County, MS.	
	Madison County, MS.	
	Rankin County, MS.	
	Simpson County, MS.	
27180	Jackson, TN	0.8900
	Chester County, TN.	
	Madison County, TN.	
27260	Jacksonville, FL	0.9537
	Baker County, FL.	
	Clay County, FL.	
	Duval County, FL.	
	Nassau County, FL.	
	St. Johns County, FL.	
27340	Jacksonville, NC	0.8401
	Onslow County, NC.	
27500	Janesville, WI	0.9583
	Rock County, WI.	
27620	Jefferson City, MO	0.8338
	Callaway County, MO.	
	Cole County, MO.	
	Moniteau County, MO.	
	Osage County, MO.	
27740	Johnson City, TN	0.8146
	Carter County, TN.	
	Unicoi County, TN.	
	Washington County, TN.	
27780	Johnstown, PA	0.8380
	Cambria County, PA.	
27860	Jonesboro, AR	0.8144
	Craighead County, AR.	
	Poinsett County, AR.	
27900	Joplin, MO	0.8721
	Jasper County, MO.	
	Newton County, MO.	
28020	Kalamazoo-Portage, MI	1.0676
	Kalamazoo County, MI.	
	Van Buren County, MI.	
28100	Kankakee-Bradley, IL	1.0603
	Kankakee County, IL.	
28140	Kansas City, MO-KS	0.9629
	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.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Lafayette County, MO.	
	Platte County, MO.	
	Ray County, MO.	
28420	Kennewick-Richland-Pasco, WA	1.0520
	Benton County, WA.	
	Franklin County, WA.	
28660	Killeen-Temple-Fort Hood, TX	0.9242
	Bell County, TX.	
	Coryell County, TX.	
	Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8240
	Hawkins County, TN.	
	Sullivan County, TN.	
	Bristol City, VA.	
	Scott County, VA.	
	Washington County, VA.	
28740	Kingston, NY	0.9000
	Ulster County, NY.	
28940	Knoxville, TN	0.8548
	Anderson County, TN.	
	Blount County, TN.	
	Knox County, TN.	
	Loudon County, TN.	
	Union County, TN.	
29020	Kokomo, IN	0.8986
	Howard County, IN.	
	Tipton County, IN.	
29100	La Crosse, WI-MN	0.9289
	Houston County, MN.	
	La Crosse County, WI.	
29140	Lafayette, IN	0.9067
	Benton County, IN.	
	Carroll County, IN.	
	Tippecanoe County, IN.	
29180	Lafayette, LA	0.8306
	Lafayette Parish, LA.	
	St. Martin Parish, LA.	
29340	Lake Charles, LA	0.7935
	Calcasieu Parish, LA.	
	Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL-WI	1.0342
	Lake County, IL.	
	Kenosha County, WI.	
29460	Lakeland, FL	0.8930
	Polk County, FL.	
29540	Lancaster, PA	0.9883
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI	0.9658
	Clinton County, MI.	
	Eaton County, MI.	
	Ingham County, MI.	
29700	Laredo, TX	0.8747
	Webb County, TX.	
29740	Las Cruces, NM	0.8784
	Dona Ana County, NM.	
29820	Las Vegas-Paradise, NV	1.1378
	Clark County, NV.	
29940	Lawrence, KS	0.8644
	Douglas County, KS.	
30020	Lawton, OK	0.8212
	Comanche County, OK.	
30140	Lebanon, PA	0.8570
	Lebanon County, PA.	
30300	Lewiston, ID-WA	0.9314
	Nez Perce County, ID.	
	Asotin County, WA.	
30340	Lewiston-Auburn, ME	0.9562
	Androscoggin County, ME.	
30460	Lexington-Fayette, KY	0.9359
	Bourbon County, KY.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Clark County, KY.	
	Fayette County, KY.	
	Jessamine County, KY.	
	Scott County, KY.	
	Woodford County, KY.	
30620	Lima, OH	0.9330
	Allen County, OH.	
30700	Lincoln, NE	1.0208
	Lancaster County, NE.	
	Seward County, NE.	
30780	Little Rock-North Little Rock, AR	0.8826
	Faulkner County, AR.	
	Grant County, AR.	
	Lonoke County, AR.	
	Perry County, AR.	
	Pulaski County, AR.	
	Saline County, AR.	
30860	Logan, UT-ID	0.9094
	Franklin County, ID.	
	Cache County, UT.	
30980	Longview, TX	0.8801
	Gregg County, TX.	
	Rusk County, TX.	
	Upshur County, TX.	
31020	Longview, WA	1.0224
	Cowlitz County, WA.	
31084	Los Angeles-Long Beach-Glendale, CA	1.1732
	Los Angeles County, CA.	
31140	Louisville, KY-IN	0.9122
	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	0.8777
	Crosby County, TX.	
	Lubbock County, TX.	
31340	Lynchburg, VA	0.9017
	Amherst County, VA.	
	Appomattox County, VA.	
	Bedford County, VA.	
	Campbell County, VA.	
	Bedford City, VA.	
	Lynchburg City, VA.	
31420	Macon, GA	0.9887
	Bibb County, GA.	
	Crawford County, GA.	
	Jones County, GA.	
	Monroe County, GA.	
	Twiggs County, GA.	
31460	Madera, CA	0.8521
	Madera County, CA.	
31540	Madison, WI	1.0306
	Columbia County, WI.	
	Dane County, WI.	
	Iowa County, WI.	
31700	Manchester-Nashua, NH	1.0642
	Hillsborough County, NH.	
	Merrimack County, NH.	
31900	Mansfield, OH	0.9189
	Richland County, OH.	
32420	Mayaguez, PR	0.4493

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Hormigueros Municipio, PR.	
	Mayaguez Municipio, PR.	
32580	McAllen-Edinburg-Pharr, TX	0.8602
	Hidalgo County, TX.	
32780	Medford, OR	1.0534
	Jackson County, OR.	
32820	Memphis, TN-MS-AR	0.9217
	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	1.0575
	Merced County, CA.	
33124	Miami-Miami Beach-Kendall, FL	0.9870
	Miami-Dade County, FL.	
33140	Michigan City-La Porte, IN	0.9332
	LaPorte County, IN.	
33260	Midland, TX	0.9384
	Midland County, TX.	
33340	Milwaukee-Waukesha-West Allis, WI	1.0076
	Milwaukee County, WI.	
	Ozaukee County, WI.	
	Washington County, WI.	
	Waukesha County, WI.	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1066
	Anoka County, MN.	
	Carver County, MN.	
	Chisago County, MN.	
	Dakota County, MN.	
	Hennepin County, MN.	
	Isanti County, MN.	
	Ramsey County, MN.	
	Scott County, MN.	
	Sherburne County, MN.	
	Washington County, MN.	
	Wright County, MN.	
	Pierce County, WI.	
	St. Croix County, WI.	
33540	Missoula, MT	0.9618
	Missoula County, MT.	
33660	Mobile, AL	0.7995
	Mobile County, AL.	
33700	Modesto, CA	1.1966
	Stanislaus County, CA.	
33740	Monroe, LA	0.7903
	Ouachita Parish, LA.	
	Union Parish, LA.	
33780	Monroe, MI	0.9506
	Monroe County, MI.	
33860	Montgomery, AL	0.8300
	Autauga County, AL.	
	Elmore County, AL.	
	Lowndes County, AL.	
	Montgomery County, AL.	
34060	Morgantown, WV	0.8730
	Monongalia County, WV.	
	Preston County, WV.	
34100	Morristown, TN	0.7790
	Grainger County, TN.	
	Hamblen County, TN.	
	Jefferson County, TN.	
34580	Mount Vernon-Anacortes, WA	1.0576
	Skagit County, WA.	
34620	Muncie, IN	0.8580
	Delaware County, IN.	
34740	Muskegon-Norton Shores, MI	0.9741

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Muskegon County, MI.	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9022
	Horry County, SC.	
34900	Napa, CA	1.2531
	Napa County, CA.	
34940	Naples-Marco Island, FL	1.0558
	Collier County, FL.	
34980	Nashville-Davidson—Murfreesboro, TN	1.0086
	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	1.2907
	Nassau County, NY.	
	Suffolk County, NY.	
35084	Newark-Union, NJ-PA	1.1687
	Essex County, NJ.	
	Hunterdon County, NJ.	
	Morris County, NJ.	
	Sussex County, NJ.	
	Union County, NJ.	
	Pike County, PA.	
35300	New Haven-Milford, CT	1.1807
	New Haven County, CT.	
35380	New Orleans-Metairie-Kenner, LA	0.9103
	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-Wayne-White Plains, NY-NJ	1.3311
	Bergen County, NJ.	
	Hudson County, NJ.	
	Passaic County, NJ.	
	Bronx County, NY.	
	Kings County, NY.	
	New York County, NY.	
	Putnam County, NY.	
	Queens County, NY.	
	Richmond County, NY.	
	Rockland County, NY.	
	Westchester County, NY.	
35660	Niles-Benton Harbor, MI	0.8847
	Berrien County, MI.	
35980	Norwich-New London, CT	1.1596
	New London County, CT.	
36084	Oakland-Fremont-Hayward, CA	1.5220
	Alameda County, CA.	
	Contra Costa County, CA.	
36100	Ocala, FL	0.9153
	Marion County, FL.	
36140	Ocean City, NJ	1.0810
	Cape May County, NJ.	
36220	Odessa, TX	0.9798
	Ector County, TX.	
36260	Ogden-Clearfield, UT	0.9216
	Davis County, UT.	
	Morgan County, UT.	
	Weber County, UT.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
36420	Oklahoma City, OK	0.8982
	Canadian County, OK.	
	Cleveland County, OK.	
	Grady County, OK.	
	Lincoln County, OK.	
	Logan County, OK.	
	McClain County, OK.	
	Oklahoma County, OK.	
36500	Olympia, WA	1.1006
	Thurston County, WA.	
36540	Omaha-Council Bluffs, NE-IA	0.9754
	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, FL	0.9742
	Lake County, FL.	
	Orange County, FL.	
	Osceola County, FL.	
	Seminole County, FL.	
36780	Oshkosh-Neenah, WI	0.9099
	Winnebago County, WI.	
36980	Owensboro, KY	0.8434
	Daviess County, KY.	
	Hancock County, KY.	
	McLean County, KY.	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1105
	Ventura County, CA.	
37340	Palm Bay-Melbourne-Titusville, FL	0.9633
	Brevard County, FL.	
37460	Panama City-Lynn Haven, FL	0.8124
	Bay County, FL.	
37620	Parkersburg-Marietta, WV-OH	0.8288
	Washington County, OH.	
	Pleasants County, WV.	
	Wirt County, WV.	
	Wood County, WV.	
37700	Pascagoula, MS	0.7974
	George County, MS.	
	Jackson County, MS.	
37860	Pensacola-Ferry Pass-Brent, FL	0.8306
	Escambia County, FL.	
	Santa Rosa County, FL.	
37900	Peoria, IL	0.8886
	Marshall County, IL.	
	Peoria County, IL.	
	Stark County, IL.	
	Tazewell County, IL.	
	Woodford County, IL.	
37964	Philadelphia, PA	1.0865
	Bucks County, PA.	
	Chester County, PA.	
	Delaware County, PA.	
	Montgomery County, PA.	
	Philadelphia County, PA.	
38060	Phoenix-Mesa-Scottsdale, AZ	0.9982
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.8673
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8736
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0439
	Berkshire County, MA.	
38540	Pocatello, ID	0.9601
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.5006
	Juana Daz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME	1.0112
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1403
	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-Fort Pierce, FL	1.0046
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1363
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	0.9892
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI-MA	1.0929
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	0.9588
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.8752
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.9441
	Charlotte County, FL.	
39540	Racine, WI	0.9045
	Racine County, WI.	
39580	Raleigh-Cary, NC	1.0057
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.8912
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9215
	Berks County, PA.	
39820	Redding, CA	1.1835
	Shasta County, CA.	
39900	Reno-Sparks, NV	1.0456
	Storey County, NV.	
	Washoe County, NV.	
40060	Richmond, VA	0.9397
	Amelia County, VA.	
	Caroline County, VA.	
	Charles City County, VA.	
	Chesterfield County, VA.	
	Cumberland County, VA.	
	Dinwiddie County, VA.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Goochland County, VA.	
	Hanover County, VA.	
	Henrico County, VA.	
	King and Queen County, VA.	
	King William County, VA.	
	Louisa County, VA.	
	New Kent County, VA.	
	Powhatan County, VA.	
	Prince George County, VA.	
	Sussex County, VA.	
	Colonial Heights City, VA.	
	Hopewell City, VA.	
	Petersburg City, VA.	
	Richmond City, VA.	
40140	Riverside-San Bernardino-Ontario, CA	1.0970
	Riverside County, CA.	
	San Bernardino County, CA.	
40220	Roanoke, VA	0.8415
	Botetourt County, VA.	
	Craig County, VA.	
	Franklin County, VA.	
	Roanoke County, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
40340	Rochester, MN	1.1504
	Dodge County, MN.	
	Olmsted County, MN.	
	Wabasha County, MN.	
40380	Rochester, NY	0.9281
	Livingston County, NY.	
	Monroe County, NY.	
	Ontario County, NY.	
	Orleans County, NY.	
	Wayne County, NY.	
40420	Rockford, IL	0.9626
	Boone County, IL.	
	Winnebago County, IL.	
40484	Rockingham County-Strafford County, NH	1.0221
	Rockingham County, NH.	
	Strafford County, NH.	
40580	Rocky Mount, NC	0.8998
	Edgecombe County, NC.	
	Nash County, NC.	
40660	Rome, GA	0.8878
	Floyd County, GA.	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.1700
	El Dorado County, CA.	
	Placer County, CA.	
	Sacramento County, CA.	
	Yolo County, CA.	
40980	Saginaw-Saginaw Township North, MI	0.9814
	Saginaw County, MI.	
41060	St. Cloud, MN	1.0215
	Benton County, MN.	
	Stearns County, MN.	
41100	St. George, UT	0.9458
	Washington County, UT.	
41140	St. Joseph, MO-KS	1.0013
	Doniphan County, KS.	
	Andrew County, MO.	
	Buchanan County, MO.	
	DeKalb County, MO.	
41180	St. Louis, MO-IL	0.9076
	Bond County, IL.	
	Calhoun County, IL.	
	Clinton County, IL.	
	Jersey County, IL.	
	Macoupin County, IL.	
	Madison County, IL.	
	Monroe County, IL.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	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	1.0556
	Marion County, OR.	
	Polk County, OR.	
41500	Salinas, CA	1.3823
	Monterey County, CA.	
41540	Salisbury, MD	0.9123
	Somerset County, MD.	
	Wicomico County, MD.	
41620	Salt Lake City, UT	0.9561
	Salt Lake County, UT.	
	Summit County, UT.	
	Tooele County, UT.	
41660	San Angelo, TX	0.8167
	Irion County, TX.	
	Tom Green County, TX.	
41700	San Antonio, TX	0.9003
	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	1.1267
	San Diego County, CA.	
41780	Sandusky, OH	0.9017
	Erie County, OH.	
41884	San Francisco-San Mateo-Redwood City, CA	1.4712
	Marin County, CA.	
	San Francisco County, CA.	
	San Mateo County, CA.	
41900	San German-Cabo Rojo, PR	0.5240
	Cabo Rojo Municipio, PR.	
	Lajas Municipio, PR.	
	Sabana Grande Municipio, PR.	
	San German Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.4722
	San Benito County, CA.	
	Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR	0.4645
	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.	
	Comero Municipio, PR.	
	Corozal Municipio, PR.	
	Dorado Municipio, PR.	
	Florida Municipio, PR.	
	Guaynabo Municipio, PR.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	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.	1.1118
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA.	1.1611
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA.	1.0771
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA.	1.4779
42140	Santa Fe, NM Santa Fe County, NM.	1.0909
42220	Santa Rosa-Petaluma, CA Sonoma County, CA.	1.2961
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL. Sarasota County, FL.	0.9629
42340	Savannah, GA Bryan County, GA. Chatham County, GA. Effingham County, GA.	0.9460
42540	Scranton—Wilkes-Barre, PA Lackawanna County, PA. Luzerne County, PA. Wyoming County, PA.	0.8543
42644	Seattle-Bellevue-Everett, WA King County, WA. Snohomish County, WA.	1.1492
43100	Sheboygan, WI Sheboygan County, WI.	0.8948
43300	Sherman-Denison, TX Grayson County, TX.	0.9617
43340	Shreveport-Bossier City, LA Bossier Parish, LA. Caddo Parish, LA. De Soto Parish, LA.	0.9132
43580	Sioux City, IA-NE-SD Woodbury County, IA. Dakota County, NE. Dixon County, NE. Union County, SD.	0.9070
43620	Sioux Falls, SD Lincoln County, SD. McCook County, SD. Minnehaha County, SD. Turner County, SD.	0.9441
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN. Cass County, MI.	0.9447
43900	Spartanburg, SC	0.9519

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Spartanburg County, SC.	
44060	Spokane, WA	1.0660
	Spokane County, WA.	
44100	Springfield, IL	0.8738
	Menard County, IL.	
	Sangamon County, IL.	
44140	Springfield, MA	1.0176
	Franklin County, MA.	
	Hampden County, MA.	
	Hampshire County, MA.	
44180	Springfield, MO	0.8557
	Christian County, MO.	
	Dallas County, MO.	
	Greene County, MO.	
	Polk County, MO.	
	Webster County, MO.	
44220	Springfield, OH	0.8748
	Clark County, OH.	
44300	State College, PA	0.8461
	Centre County, PA.	
44700	Stockton, CA	1.0564
	San Joaquin County, CA.	
44940	Sumter, SC	0.8520
	Sumter County, SC.	
45060	Syracuse, NY	0.9468
	Madison County, NY.	
	Onondaga County, NY.	
	Oswego County, NY.	
45104	Tacoma, WA	1.1078
	Pierce County, WA.	
45220	Tallahassee, FL	0.8655
	Gadsden County, FL.	
	Jefferson County, FL.	
	Leon County, FL.	
	Wakulla County, FL.	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9024
	Hernando County, FL.	
	Hillsborough County, FL.	
	Pasco County, FL.	
	Pinellas County, FL.	
45460	Terre Haute, IN	0.8517
	Clay County, IN.	
	Sullivan County, IN.	
	Vermillion County, IN.	
	Vigo County, IN.	
45500	Texarkana, TX-Texarkana, AR	0.8413
	Miller County, AR.	
	Bowie County, TX.	
45780	Toledo, OH	0.9524
	Fulton County, OH.	
	Lucas County, OH.	
	Ottawa County, OH.	
	Wood County, OH.	
45820	Topeka, KS	0.8904
	Jackson County, KS.	
	Jefferson County, KS.	
	Osage County, KS.	
	Shawnee County, KS.	
	Wabaunsee County, KS.	
45940	Trenton-Ewing, NJ	1.0276
	Mercer County, NJ.	
46060	Tucson, AZ	0.8926
	Pima County, AZ.	
46140	Tulsa, OK	0.8690
	Creek County, OK.	
	Okmulgee County, OK.	
	Osage County, OK.	
	Pawnee County, OK.	
	Rogers County, OK.	
	Tulsa County, OK.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Wagoner County, OK.	
46220	Tuscaloosa, AL	0.8336
	Greene County, AL.	
	Hale County, AL.	
	Tuscaloosa County, AL.	
46340	Tyler, TX	0.9502
	Smith County, TX.	
46540	Utica-Rome, NY	0.8295
	Herkimer County, NY.	
	Oneida County, NY.	
46660	Valdosta, GA	0.8341
	Brooks County, GA.	
	Echols County, GA.	
	Lanier County, GA.	
	Lowndes County, GA.	
46700	Vallejo-Fairfield, CA	1.4279
	Solano County, CA.	
46940	Vero Beach, FL	0.9477
	Indian River County, FL.	
47020	Victoria, TX	0.8470
	Calhoun County, TX.	
	Goliad County, TX.	
	Victoria County, TX.	
47220	Vineland-Millville-Bridgeton, NJ	1.0573
	Cumberland County, NJ.	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.8894
	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	0.9975
	Tulare County, CA.	
47380	Waco, TX	0.8146
	McLennan County, TX.	
47580	Warner Robins, GA	0.8489
	Houston County, GA.	
47644	Warren-Farmington Hills-Troy, MI	1.0112
	Lapeer County, MI.	
	Livingston County, MI.	
	Macomb County, MI.	
	Oakland County, MI.	
	St. Clair County, MI.	
47894	Washington-Arlington-Alexandria, DC-VA&-MD-WV	1.1023
	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.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
	Falls Church City, VA.	
	Fredericksburg City, VA.	
	Manassas City, VA.	
	Manassas Park City, VA.	
	Jefferson County, WV.	
47940	Waterloo-Cedar Falls, IA	0.8633
	Black Hawk County, IA.	
	Bremer County, IA.	
	Grundy County, IA.	
48140	Wausau, WI	0.9570
	Marathon County, WI.	
48260	Weirton-Steubenville, WV-OH	0.8280
	Jefferson County, OH.	
	Brooke County, WV.	
	Hancock County, WV.	
48300	Wenatchee, WA	0.9427
	Chelan County, WA.	
	Douglas County, WA.	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0362
	Palm Beach County, FL.	
48540	Wheeling, WV-OH	0.7449
	Belmont County, OH.	
	Marshall County, WV.	
	Ohio County, WV.	
48620	Wichita, KS	0.9457
	Butler County, KS.	
	Harvey County, KS.	
	Sedgwick County, KS.	
	Sumner County, KS.	
48660	Wichita Falls, TX	0.8332
	Archer County, TX.	
	Clay County, TX.	
	Wichita County, TX.	
48700	Williamsport, PA	0.8485
	Lycoming County, PA.	
48864	Wilmington, DE-MD-NJ	1.1049
	New Castle County, DE.	
	Cecil County, MD.	
	Salem County, NJ.	
48900	Wilmington, NC	0.9237
	Brunswick County, NC.	
	New Hanover County, NC.	
	Pender County, NC.	
49020	Winchester, VA-WV	1.0496
	Frederick County, VA.	
	Winchester City, VA.	
	Hampshire County, WV.	
49180	Winston-Salem, NC	0.9401
	Davie County, NC.	
	Forsyth County, NC.	
	Stokes County, NC.	
	Yadkin County, NC.	
49340	Worcester, MA	1.0996
	Worcester County, MA.	
49420	Yakima, WA	1.0322
	Yakima County, WA.	
49500	Yauco, PR	0.4493
	Guánica Municipio, PR.	
	Guayanilla Municipio, PR.	
	Peñuelas Municipio, PR.	
	Yauco Municipio, PR.	
49620	York-Hanover, PA	0.9150
	York County, PA.	
49660	Youngstown-Warren-Boardman, OH-PA	0.9237
	Mahoning County, OH.	
	Trumbull County, OH.	
	Mercer County, PA.	
49700	Yuba City, CA	1.0363
	Sutter County, CA.	
	Yuba County, CA.	

TABLE 2A.—PROPOSED INPATIENT REHABILITAION FACILITY WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Urban area (Constituent counties)	Full wage Index
49740	Yuma, AZ Yuma County, AZ.	0.8871

TABLE 2B.—PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX (BASED ON PROPOSED CBSA LABOR MARKET AREAS) FOR RURAL AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005

CBSA code	Nonurban area	Full wage index
01	Alabama	0.7628
02	Alaska	1.1746
03	Arizona	0.8936
04	Arkansas	0.7406
05	California	1.0524
06	Colorado	0.9368
07	Connecticut	1.1917
08	Delaware	0.9503
10	Florida	0.8574
11	Georgia	0.7733
12	Hawaii	1.0522
13	Idaho	0.8227
14	Illinois	0.8339
15	Indiana	0.8653
16	Iowa	0.8475
17	Kansas	0.8079
18	Kentucky	0.7755
19	Louisiana	0.7345
20	Maine	0.9039
21	Maryland	0.9220
22	Massachusetts [2]	1.0216

TABLE 2B.—PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX (BASED ON PROPOSED CBSA LABOR MARKET AREAS) FOR RURAL AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Nonurban area	Full wage index
23	Michigan	0.8786
24	Minnesota	0.9330
25	Mississippi	0.7635
26	Missouri	0.7762
27	Montana	0.8701
28	Nebraska	0.9035
29	Nevada	0.9280
30	New Hampshire	0.9940
31	New Jersey [1]	
32	New Mexico	0.8680
33	New York	0.8151
34	North Carolina	0.8563
35	North Dakota	0.7743
36	Ohio	0.8693
37	Oklahoma	0.7686
38	Oregon	0.9914
39	Pennsylvania	0.8310
40	Puerto Rico [2]	0.4047
41	Rhode Island [1]	
42	South Carolina	0.8683
43	South Dakota	0.8398

TABLE 2B.—PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX (BASED ON PROPOSED CBSA LABOR MARKET AREAS) FOR RURAL AREAS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2005—Continued

CBSA code	Nonurban area	Full wage index
44	Tennessee	0.7869
45	Texas	0.7966
46	Utah	0.8287
47	Vermont	0.9375
48	Virgin Islands	0.7456
49	Virginia	0.8049
50	Washington	1.0312
51	West Virginia	0.7865
52	Wisconsin	0.9492
53	Wyoming	0.9182
65	Guam	0.9611

[1] All counties within the State are classified urban.

[2] Massachusetts and Puerto Rico have areas designated as rural, however, no short-term, acute care hospitals are located in the area(s) for FY 2006 under CBSA-based designations. Therefore, we are proposing to use FY 2001 MSA based hospital wage data.

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
26T107	9TH FLOOR REHAB	26470	3760	28140
39T231	DABINGTON MEMORIAL HOSPITAL	39560	6160	37964
193067	ACADIA REHABILITATION HOSPITAL	19000	3880	19
24T043	ACUTE CARE REHABILITATION-ALMC	24230	24	24
42T070	ACUTE REHAB UNIT AT TUOMEY HEALTHCARE SYSTEM	42420	8140	44940
14T182	ADVOCATE ILLINOIS MASONIC MEDICAL CENTER	14141	1600	16974
14T223	ADVOCATE LUTHERAN GENERAL HOSPITAL	14141	1600	16974
19T202	AHS SUMMIT HOSPITAL LLC	19160	0760	12940
05T320	ALAMEDA COUNTY MEDICAL CENTER	05000	5775	36084
02T017	ALASKA REGIONAL HOSPITAL	02020	0380	11260
33T013	ALBANY MEDICAL CENTER HOSP	33000	0160	10580
14T258	ALEXIAN BROTHERS MEDICAL CENTER	14141	1600	16974
05T281	ALHAMBRA HOSPITAL MEDICAL CENTER	05200	4480	31084
52T096	ALL SAINTS HEALTHCARE, INC.	52500	6600	39540
39T074	ALLEGHENY GENERAL HOSPITAL SUBURBAN CAMPUS	39010	6280	38300
17T116	ALLEN COUNTY HOSPITAL	17000	17	17
36T131	ALLIANCE COMMUNITY HOSPITAL	36770	1320	15940
393030	ALLIED SERVICES INST OF REHAB SERVICES	39420	7560	42540
05T305	ALTA BATES MEDICAL CENTER	05000	5775	36084
39T073	ALTOONA HOSPITAL	39120	0280	11020
39T121	ALTOONA REGIONAL HEALTH SYSTEM	39120	0280	11020
35T019	ALTRU REHABILITATION CENTER	35170	2985	24220
05T583	ALVARADO HOSPITAL MEDICAL CENTER INC.	05470	7320	41740
33T010	AMSTERDAM MEMORIAL HOSPITAL	33380	0160	33

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
01T036	ANDALUSIA REGIONAL HOSPITAL	01190	01	01
393051	ANGELA JANE PAVILION	39620	6160	37964
423029	ANMED HEALTHSOUTH REHABILITATION HOSPITAL	42030	3160	11340
04T039	ARKANSAS METHODIST HOSPITAL	04270	04	04
39T163	ARMSTRONG COUNTY MEMORIAL HOSPITAL	39070	39	38300
11T115	ATLANTA MEDICAL CENTER	11470	0520	12060
15T074	AUGUST F. HOOK REHAB CENTER	15480	3480	26900
49T018	AUGUSTA MEDICAL CENTER	49891	49	49
52T193	AURORA BAYCARE MEDICAL CENTER	52040	3080	24580
52T102	AURORA LAKELAND MEDICAL CENTER REHAB UNIT	52630	52	52
52T035	AURORA SHEBOYGAN MEMORIAL MEDICAL CENTER REHAB UNI	52580	7620	43100
52T064	AURORA SINAI MEDICAL CENTER	52390	5080	33340
43T016	AVERA MCKENNAN HOSPITAL	43490	7760	43620
43T012	AVERA SACRED HEART HOSPITAL	43670	43	43
43T014	AVERA ST. LUKE'S	43060	43	43
45T280	BACHARACH INSTITUTE FOR REHABILITATION	31000	1920	19124
313030	BALL MEMORIAL HOSPITAL-REHAB	15170	0560	12100
15T089	BAPTIST HEALTH REHABILITATION INSTITUTE	04590	5280	34620
043026	BAPTIST HEALTH SYSTEM	45130	4400	30780
45T058	BAPTIST HOSPITAL DAVIS CTR FOR REHABILITATION	10120	7240	41700
10T008	BAPTIST HOSPITAL DESOTO	25160	5000	33124
25T141	BAPTIST HOSPITAL EAST	18550	4920	32820
18T130	BAPTIST HOSPITALS OF SOUTHEAST TEXAS	45700	4520	31140
45T346	BAPTIST MEMORIAL HOSPITAL NORTH MISSISSIPPI	25350	0840	13140
25T034	BAPTIST MEMORIAL MED CENTER, NO LITTLE ROCK	04590	25	25
04T036	BAPTIST REGIONAL MEDICAL CENTER	18990	4400	30780
18T080	BAPTIST REHAB CENTER	44180	18	18
44T133	BAPTIST REHABILITATION GERMANTOWN	44780	5360	34980
44T147	BARBERTON CITIZENS HOSPITAL	36780	4920	32820
36T019	BARTLETT REGIONAL HOSPITAL	02110	0080	10420
02T008	BASTROP REHABILITATION HOSPITAL	19330	02	02
193058	BATON ROUGE GENERAL MEDICAL CENTER	19160	19	19
19T065	BAXTER REGIONAL MEDICAL CENTER	04020	0760	12940
04T027	BAY MEDICAL CENTER FOR REHABILITATION	23080	04	04
23T041	BAYHEALTH MEDICAL CENTER	08000	6960	13020
08T004	BAYLOR ALL SAINTS MEDICAL CENTER OF FORT WORTH	45910	2190	20100
45T137	BAYLOR INSTITUTE FOR REHABILITATION AT GASTON	45390	2800	23104
453036	BAYLOR MEDICAL CENTER	45390	1920	19124
45T079	BAYLOR MEDICAL CENTER AT GARLAND	45390	1920	19124
45T097	BAYSHORE MEDICAL CENTER	45610	3360	26420
27T012	BELLEVUE HOSPITAL CENTRE	33420	3040	24500
33T204	BELMONT COMMUNITY HOSPITAL	36060	5600	35644
36T153	BELOIT MEMORIAL HOSPITAL	52520	9000	48540
52T100	BENEDICTINE HOSPITAL	33740	3620	27500
33T224	BENEFIS HEALTHCARE	27060	33	28740
15T088	BENNETT REHAB CENTER SAINT JOHN'S HEALTH SYSTEM	15470	3480	11300
193070	BENTON REHABILITATION HOSPITAL	19160	0760	12940
36T170	BERGER HEALTH SYSTEM	36660	1840	18140
22T046	BERKSHIRE MEDICAL CENTER	22010	6323	38340
33T169	BETH ISRAEL MEDICAL CENTER	33420	5600	35644
36T179	BETHESDA NORTH HOSPITAL	36310	1640	17140
01T104	BIRMINGHAM BAPT MED CNTR MONTCLAIR SNU	01360	1000	13820
10T213	BLAKE MEDICAL CENTER	10400	7510	42260
14T015	BLESSING HOSPITAL	14000	14	14
23T135	BOGALUSA COMMUNITY REHABILITAION HOSPITAL	19580	2160	19804
193052	BON SECOUR ST. FRANCIS INPATIENT REHAB CENTER	42220	19	19
42T023	BONE AND JOINT HOSPITAL REHAB CENTER	37540	3160	24860
37T105	BOONE HOSPITAL CENTER	26090	5880	36420
26T068	BORGESS-PIPP HEALTH CENTER	23380	1740	17860
23T117	BOSTON MED CTR CORP/UNIVE HOSP CAMPUS	22160	3720	28020
22T031	BOTHWELL REGIONAL HEALTH CENTER	26790	1123	14484
26T009	BOTSFORD GENERAL HOSPITAL	23620	26	26
23T151	BOULDER COMMUNITY HOSPITAL	06060	2160	47644
06T027	BRANDYWINE HOSPITAL	39210	1125	14500
39T076	BRAZOSPORT MEMORIAL HOSPITAL	45180	6160	37964
45T072	BRIDGEPORT HOSPITAL	07010	1145	26420
07T010	BROADWAY METHODIST REHAB	15440	3283	25540

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
15T132	BROKEN ARROW REHABILITATION	37710	2960	23844
37T176	BROMENN REGIONAL MEDICAL CENTER	14650	8560	46140
14T127	BRONSON VICKSBURG HOSPITAL	23380	1040	14060
23T190	BROOKS REHABILITATION HOSPITAL	10150	3720	28020
103039	BROOKWOOD MEDICAL CENTER	01360	3600	27260
01T139	BROTMAN MEDICAL CENTER	05200	1000	13820
05T144	BROWNSVILLE GENERAL HOSPITAL	39330	4480	31084
39T166	BROWNWOOD REGIONAL MEDICAL CENTER	45220	6280	38300
45T587	BRUNSWICK HOSPITAL	33700	45	45
33T314	BRYANLGH MEDICAL CENTER WEST	28540	5380	35004
28T003	BRYANT T. ALDRIDGE REHABILITATION CENTER	34630	4360	30700
34T147	BRYN MAWR REHABILITATION HOSPITAL	39210	6895	40580
393025	BSA HEALTH SYSTEM	45860	6160	37964
45T231	BUFFALO MERCY REHABILITATION UNIT	33240	0320	11100
33T279	BURBANK REHABILITATION CENTER	22170	1280	15380
22T001	BURKE REHABILIATION HOSPITAL	33800	1123	49340
333028	CABRINI MEDICAL CENTER	33420	5600	35644
39T160	CALDWELL MEMORIAL HOSPITAL	19100	6280	38300
33T133	CAMERON REGIONAL MEDICAL CTR	26240	5600	35644
19T190	CANONSBURG GENERAL HOSPITAL	39750	19	19
26T057	CAPITAL REGION MEDICAL CENTER	26250	3760	28140
26T047	CARDINAL HILL REHABILITATION HOSPITAL	18330	26	27620
183026	CARILION HEALTH SYSTEM	49801	4280	30460
49T024	CARLE FOUNDATION HOSPITAL	14090	6800	40220
14T091	CARLISLE REGIONAL MEDICAL CENTER	39270	1400	16580
39T058	CARLSBAD MEDICAL CENTER	32070	3240	25420
32T063	CAROLINAS HOSPITAL SYSTEM	42200	32	32
42T091	CARONDELET ST JOSEPHS HOSPITAL	03090	2655	22500
03T011	CARONDELET ST MARYS HOSPITAL	03090	8520	46060
03T010	CARSON REHABILITATION CENTER	29120	8520	46060
293029	CARTHAGE AREA HOSPITAL	33330	29	16180
33T263	CASA COLINA HOSP FOR REHAB MEDICINE	05200	33	33
053027	CATAWBA VALLEY MEDICAL CENTER	34170	4480	31084
34T143	CATHOLIC MEDICAL CENTER	30050	3290	25860
30T034	CATSKILL REGIONAL MEDICAL CENTER	33710	1123	31700
33T386	CAYUGA MEDICAL CENTER	33730	33	33
33T307	CCMH INPATIENT REHAB	39640	33	27060
39T246	CEDARS-SINAI MEDICAL CENTER	05200	39	39
44T161	CENTENNIAL MEDICAL CENTER	44180	5360	34980
05T625	CENTINELA HOSPITAL MEDICAL CENTER	05200	4480	31084
05T240	CENTRAL ARKANSAS HOSPITAL	04720	4480	31084
04T014	CENTRAL KANSAS MEDICAL CENTER	17040	04	04
17T033	CENTRAL MAINE REHABILITATION CENTER	20000	17	17
20T024	CENTRAL MONTGOMERY MEDICAL CENTER	39560	4243	30340
39T012	CENTURA HEALTH-ST. ANTHONY CENTRAL HOSPITAL	06150	6160	37964
06T015	CGRMC ACUTE REHABILITATION UNIT	03100	2080	19740
03T016	CHALMETTE MEDICAL CENTER	19430	6200	38060
45T035	CHAMBERSBURG HOSPITAL	39350	3360	26420
45T237	CHARLESTON AREA MED CNTR	51190	7240	41700
19T185	CHARLOTTE INSTITUTE OF REHABILITATION	34590	5560	35380
39T151	CHATTANOOGA	44320	39	39
51T022	CHELSEA COMMUNITY HOSPITAL	23800	1480	16620
343026	CHESHIRE MEDICAL CENTER	30020	1520	16740
44T162	CHESTNUT HILL REHABILITATION HOSPITAL	39620	1560	16860
23T259	CHNE REHAB	26940	0440	11460
30T019	CHRISTUS JASPER MEMORIAL HOSPITAL	45690	30	30
393032	CHRISTUS SANTA ROSA HOSPITAL	45130	6160	37964
26T180	CHRISTUS SCHUMPERT HEALTH SYSTEM	19080	7040	41180
45T573	CHRISTUS SPOHN HOSPITAL SHORELINE	45830	45	45
19T041	CHRISTUS ST MICHAEL REHAB HOSPITAL	45170	7680	43340
45T046	CHRISTUS ST. FRANCES CABRINI HOSPITAL	19390	1880	18580
453065	CHRISTUS ST. JOHN	45610	8360	45500
19T019	CHRISTUS ST. JOSEPH HOSPITAL	45610	0220	10780
45T709	CHRISTUS ST. PATRICK HOSPITAL	19090	3360	26420
19T027	CHS,INC DBA ST CHARLES MEDICAL CTR	38080	3960	29340
38T047	CITRUS VALLEY MEDICAL CENTER-VQ CAMPUS	05200	38	13460
05T369	CJW INPATIENT REHAB	49791	4480	31084

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
49T112	CL	45610	6760	40060
45T617	CLAXTON-HEPBURN MEDICAL CENTER	33630	3360	26420
33T211	CLINCH VALLEY MEDICAL CENTER	49920	33	33
49T060	CLINTON MEMORIAL HOSPITAL	36130	49	49
36T175	COASTAL REHABILITATION CTR	34240	36	36
36T172	COLISEUM REHABILITATION CENTER	11090	1680	17460
34T131	COLLEGE STATION MEDICAL CENTER	45190	34	34
11T164	COLLETON MEDICAL CENTER	42140	4680	31420
45T299	COLORADO PLAINS MEDICAL CTR	06430	1260	17780
42T030	COLORADO RIVER MEDICAL CENTER	05460	42	42
06T044	COLUMBIA HOSPITAL	52390	06	06
05T469	COLUMBIA REGIONAL HOSPITAL	26090	6780	40140
52T140	COLUMBUS REGIONAL HOSPITAL	15020	5080	33340
26T178	COMANCHE COUNTY MEMORIAL HOSPITAL	37150	1740	17860
15T112	COMMUNITY GENERAL HOSPITAL PM&R	33520	15	18020
37T056	COMMUNITY HEALTH PARTNERS OF OH-WEST	36480	4200	30020
33T159	COMMUNITY HOSPITAL LOS GATOS	05530	8160	45060
05T188	COMMUNITY HOSPITAL OF SPRINGFIELD	36110	7400	41940
36T187	COMMUNITY HOSPITAL/WELLNESS CTRS MONTPELI	36870	2000	44220
36R327	COMMUNITY HOSPITALS OF WILLIAMS COUNTY	36870	36	36
36T121	COMMUNITY HOSPTIAL	15440	36	36
15T125	COMMUNITY MEDICAL CENTER	27310	2960	23844
27T023	COMMUNITY MEMORIAL HOSPITAL	52660	5140	33540
52T103	COMMUNITY REHABILITATION CENTER	23100	5080	33340
23T078	COMMUNITY REHABILITATION HOSPITAL OF COUSHATTA	19400	0870	35660
193080	CONEY ISLAND HOSPITAL	33331	19	19
33T196	CORNERSTONE REHABILITATION HOSPITAL	45650	5600	35644
453085	CORONA REGINAL MEDICAL CENTER	05430	4880	32580
05T329	CORPUS CHRISTI WARM SPGS REHAB HOSP	45830	6780	40140
453055	COTTAGE HOSPITAL	23810	1880	18580
45T040	COVENANT HEALTH SYSTEM	45770	4600	31180
23T070	COVENANT HEALTHCARE	23720	6960	40980
16T067	COVENANT MEDICAL CENTER	16060	8920	47940
26T040	COX HEALTH SYSTEMS	26380	7920	44180
05T008	CPMC REGIONAL REHABILITATION CENTER	05480	7360	41884
39T110	CRICHTON REHABILITATION CENTER	39160	3680	27780
04T042	CRITTENDEN MEMORIAL HOSPITAL	04170	4920	32820
23T254	CRITTENTON REHABCENTRE	23730	2160	47644
44T175	CROCKETT HOSPITAL REHAB	44490	44	44
26T198	CROSSROADS REGIONAL MEDICAL CENTER	26910	7040	41180
193088	CROWLEY REHAB HOSP, LLC	19000	3880	19
39T180	CROZER CHESTER MEDICAL CENTER	39290	6160	37964
34T008	CTR FOR REHAB SCOTLAND MEMORIAL HOSPIT	34820	34	34
39T233	CTR. FOR ACUTE REHABILITATIVE MEDICINE AT HANOVER	39800	9280	49620
07T033	DANBURY HOSPITAL	07000	5483	14860
05T729	DANIEL FREEMAN	05200	4480	31084
49T075	DANVILLE REGIONAL MEDICAL CENTER	49241	1950	19260
19T003	DAUTERIVE HOSPITAL	19220	19	19
15T061	DAVIESS COMMUNITY HOSPITAL	15130	15	15
46T041	DAVIS HOSPITAL AND MEDICAL CENTER	46050	7160	36260
36T038	DEACONESS HOSPITAL	36310	1640	17140
37T032	DEACONESS HOSPITAL	37540	5880	36420
15T019	DEACONESS ST. JOSEPHS	15180	15	15
11T076	DEKALB MEDICAL CENTER REHABILITATION	11370	0520	12060
03T093	DEL E. WEBB MEMORIAL HOSPITAL	03060	6200	38060
45T646	DEL SOL MEDICAL CENTER	45480	2320	21340
39T081	DELAWARE COUNTY MEMORIAL HOSPITAL	39290	6160	37964
25T082	DELTA REGIONAL MEDICAL CENTER	25750	25	25
45T634	DENTON REGIONAL MEDICAL CENTER	45410	1920	19124
06T011	DENVER HEALTH MEDICAL CENTER	06150	2080	19740
49T011	DEPAUL CENTER FOR PHYSICAL REHABILITATION	49641	5720	47260
26T176	DES PERES HOSPITAL	26940	7040	41180
05T243	DESERT REGIONAL MEDICAL CENTER	05430	6780	40140
45T147	DETAR HOSPITAL	45948	8750	47020
19T115	DOCTORS HOSPITAL	11840	7680	43340
11T177	DOCTORS HOSPITAL OF OPELOUSAS	19480	0600	12260
19T191	DOCTORS HOSPITAL OF SHREVEPORT	19080	3880	19

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
36T151	DOCTORS HOSPITAL OF STARK COUNTY	36770	1320	15940
05T242	DOMINICAN HOSPITAL	05540	7485	42100
39T203	DOYLESTOWN HOSPITAL	39140	6160	37964
46T021	DRMC ACUTE REHABILITATION	46260	46	41100
39T086	DUBOIS REGNL MED CNTR	39230	39	39
34T155	DURHAM REGIONAL HOSPITAL	34310	6640	20500
23T230	E W SPARROW INPATIENT REHAB	23320	4040	29620
19T146	EAST JEFFERSON GENERAL HOSPITAL	19250	5560	35380
453072	EAST TEXAS MED CTR REHAB HOSP	45892	8640	46340
01T011	EASTERN HEALTH REHAB CENTER, MCE	01360	1000	13820
20T033	EASTERN MAINE MEDICAL CENTER	20090	0733	12620
39T162	EASTON HOSPITAL	39590	0240	10900
333029	EDDY COHOES REHABILITATION CTR	33000	0160	10580
45T119	EDINBURG REGIONAL MEDICAL	45650	4880	32580
36T241	EDWIN SHAW REHABILITATION HOSPITAL	36780	0080	10420
14T208	EHS CHRIST HOSPITAL & MEDICAL CENTER	14141	1600	16974
03T080	EL DORADO HOSPITAL	03090	8520	46060
15T018	ELKHART GENERAL HEALTHCARE SYSTEMS	15190	2330	21140
39T289	ELKINS PARK HOSPITAL	39560	6160	37964
33T128	ELMHURST HOSPITAL CENTER	33590	5600	35644
11T010	EMORY HOSPITAL CTR FOR REHAB	11370	0520	12060
05T158	ENCINO-TARZANA REGIONAL MEDICAL CENTER	05200	4480	31084
05T039	ENLOE MEDICAL CENTER	05030	1620	17020
45T833	ENNIS REGIONAL MEDICAL CENTER	45470	1920	19124
39T225	EPHRATA COMMUNITY HOSPITAL	39440	4000	29540
33T219	ERIE COUNTY MEDICAL CENTER	33240	1280	15380
19T078	EUNICE COMMUNITY MEDICAL CENTER	19480	3880	19
39T013	EVANGELICAL COMMUNITY HOSPITAL	39720	39	39
14T010	EVANSTON NORTHWESTERN HEALTHCARE	14141	1600	16974
50T124	EVERGREEN HEALTHCARE	50160	7600	42644
36T072	FAIRFIELD MEDICAL CENTER	36230	1840	18140
223029	FAIRLAWN REHABILITATION HOSPITAL	22170	1123	49340
36T077	FAIRVIEW HOSPITAL	36170	1680	17460
11T125	FAIRVIEW PARK HOSPITAL	11660	11	11
28T125	FAITH REGIONAL HEALTH SERVICES	28590	28	28
10T236	FAWCETT MEMORIAL HOSPITAL	10070	6580	39460
33T044	FAXTON-ST. LUKES HEALTHCARE	33510	8680	46540
15T064	FAYETTE MEMORIAL HOSPITAL	15200	15	15
36T025	FIRELANDS REGIONAL MEDICAL CENTER	36220	36	41780
34T115	FIRSTHEALTH MOORE REGIONAL HOSPITAL	34620	34	34
47T003	FLETCHER ALLEN HEALTH CARE	47030	1303	15540
10T068	FLORIDA HOSPITAL ORMOND DIVISION	10630	2020	19660
10T007	FLORIDA HOSPITAL REHABILITATION AND SPORTS MEDICIN	10470	5960	36740
36T074	FLOWER REHABILITATION CENTER	36490	8400	45780
11T054	FLOYD MEDICAL CENTER	11460	11	40660
39T267	FORBES REGIONAL HOSPITAL	39010	6280	38300
26T021	FOREST PARK	26950	7040	41180
25T078	FORREST GENERAL HOSPITAL REHAB UNIT	25170	3285	25620
36T132	FORT REHABILITATION CENTER	36080	3200	17140
10T223	FORT WALTON BEACH MEDICAL CENT	10450	2750	23020
453041	FORT WORTH REHABILITATION HOSPITAL	45910	2800	23104
26T137	FR	26480	3710	27900
52T004	FRANCISCAN SKEMP MEDICAL CENTER REHAB	52310	3870	29100
18T040	FRAZIER REHAB INSTITUTE	18550	4520	31140
17T074	FRED C BRAMLAGE INPATIENT REHABILITATION UNIT	17300	17	17
52T177	FROEDTERT MEMORIAL LUTHERAN HOSPITAL	52390	5080	33340
34T116	FRYE REGIONAL MEDICAL CENTER	34170	3290	25860
36T194	GALION COMMUNITY HOSPITAL	36160	4800	36
23T244	GARDEN CITY HOSPITAL	23810	2160	19804
05T432	GARFIELD MEDICAL CENTER	05200	4480	31084
44T035	GATEWAY MEDICAL CENTER	44620	1660	17300
14T125	GATEWAY REGIONAL MEDICAL CENTER	14680	7040	41180
183031	GATEWAY REHAB HOSPITAL	18550	4520	31140
183030	GATEWAY REHABILITATION HOSPITAL	18070	1640	17140
33T058	GE	33530	6840	40380
393047	GEISINGER HEALTHSOUTH REHABILITATION HOSPITAL	39580	39	39
39T270	GEISINGER WYOMING VALLEY MEDICAL CENTER	39480	7560	42540

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
36T039	GENESIS HEALTH CARE SYSTEM	36610	36	36
16T033	GENESIS MEDICAL CENTER	16810	1960	19340
23T197	GENESYS REGIONAL MEDICAL CTR	23240	2640	22420
373026	GEORGE NIGH REBABILITATION CTR	37550	37	46140
45T191	GEORGETOWN HEALTHCARE SYSTEM	45970	0640	12420
11T087	GLANCY	11530	0520	12060
05T239	GLENDALE ADVENTIST MEDICAL CENTER	05200	4480	31084
05T058	GLENDALE MEMORIAL HOSPITAL	05200	4480	31084
33T191	GLENS FALLS HOSPITAL	33750	2975	24020
19T160	GLENWOOD REHABILITATION CENTER	19360	5200	33740
26T175	GOLDEN VALLEY MEMORIAL HO INPATIENT REHAB FACILITY	26410	26	26
05T471	GOOD SAMARITAN HOSPITAL	05200	4480	31084
15T042	GOOD SAMARITAN HOSPITAL	15410	15	15
28T009	GOOD SAMARITAN HOSPITAL	28090	28	28
36T134	GOOD SAMARITAN HOSPITAL	36310	1640	17140
50T079	GOOD SAMARITAN HOSPITAL	50260	8200	45104
14T046	GOOD SAMARITAN REGIONAL HEALTH CENTER	14490	14	14
03T002	GOOD SAMARITAN REHABILITATION INSTITUTE	03060	6200	38060
39T031	GOOD SAMARITAN-STINE ACUTE REHAB	39650	39	39
45T037	GOOD SHEPHERD MEDICAL CENTER	45570	4420	30980
393035	GOOD SHEPHERD REHABILITATION HOSPITAL	39470	0240	10900
393050	GOOD SHEPHERD REHABILITATION HOSPITAL	39590	0240	10900
24T064	GRAND ITASCA CLINIC & HOSPITAL	24300	24	24
36T133	GRANDVIEW MEDICAL CENTER	36580	2000	19380
36T017	GRANT/RIVERSIDE METHODIST HOSPITALS	36250	1840	18140
23T030	GRATIOT COMMUNITY HOSPITAL	23280	23	23
16T057	GREAT RIVER MEDICAL CENTER	16280	16	16
09T008	GREATER SOUTHEAST COMMUNITY HOSPITAL	09000	8840	47894
363032	GREENBRIAR REHABILITATION HOSPITAL	36510	9320	49660
36T026	GREENE MEMORIAL HOSPITAL	36290	2000	19380
05T026	GROSSMONT HOSPITAL SHARP	05470	7320	41740
45T104	GUADALUPE VALLEY HOSPITAL	45581	7240	41700
45T214	GULF COAST MEDICAL CENTER	45954	45	45
52T087	GUNDERSEN LUTHERAN MEDICAL CENTER,INC.	52310	3870	29100
39T185	GUNDERSON REHABILITATION CENTER	39480	7560	42540
513028	H/S REHAB HOSPITAL OF HUNTINGTON	51050	3400	26580
23T066	HACKLEY HOSPITAL	23600	3000	34740
36T137	HANNA HOUSE INPATIENT REHAB CENTER	36170	1680	17460
50T064	HARBORVIEW MEDICAL CENTER	50160	7600	42644
33T240	HARLEM HOSPITAL/COLUMBIA UNIVERSITY	33420	5600	35644
45T289	HARRIS COUNTY HOSPITAL DISTRICT	45610	3360	26420
45T135	HARRIS METHODIST FORT WORTH	45910	2800	23104
45T639	HARRIS METHODIST HEB	45910	2800	23104
07T025	HARTFORD HOSPITAL	07010	3283	25540
03T069	HAVASU REGIONAL MEDICAL CENTER	03070	4120	03
17T013	HAYS MEDICAL CENTER	17250	17	17
18T029	HAZARD ARH REGIONAL MEDICAL CENTER	18960	18	18
013028	HEALTH SOUTH REHAB HOSPITAL OF MONTGOMERY	01500	5240	33860
23T275	HEALTHSOURCE SAGINAW	23720	6960	40980
053031	HEALTHSOUTH BAKERSFIELD REHAB HOSPITAL	05140	0680	12540
223027	HEALTHSOUTH BRAINTREE REHAB HOSPITAL	22130	1123	14484
443030	HEALTHSOUTH CANE CREEK REHAB HOSPITAL	44910	44	44
113027	HEALTHSOUTH CENTRAL GA REHAB HOSPITAL	11090	4680	31420
213028	HEALTHSOUTH CHESAPEAKE REHAB HOSPITAL	21220	21	41540
103040	HEALTHSOUTH EMERALD COAST REHABILITATION HOSPITAL	10020	6015	37460
393027	HEALTHSOUTH HARMARVILLE REHABILITATION HOSPITAL	39010	6280	38300
013025	HEALTHSOUTH LAKESHORE REHABILITATION HOSPITAL	01360	1000	13820
033025	HEALTHSOUTH MERIDIAN POINT REHAB HOSP	03060	6200	38060
513030	HEALTHSOUTH MOUNTAINVIEW REGIONAL REHAB HOSPITAL	51300	51	34060
393039	HEALTHSOUTH NITTANY VALLEY REHABILITATION HOSPITAL	39200	8050	44300
183027	HEALTHSOUTH NORTHERN KENTUCKY REHABILITATION	18580	1640	17140
393040	HEALTHSOUTH OF ALTOONA, INC	39120	0280	11020
423027	HEALTHSOUTH OF CHARLESTON, INC	42170	1440	16700
453047	HEALTHSOUTH PLANO REHABILITATION HOSP	45310	1920	19124
043032	HEALTHSOUTH REHAB HOSP IN PART WITH RE	04710	2580	22220
453044	HEALTHSOUTH REHAB HOSP OF AUSTIN	45940	0640	12420
183028	HEALTHSOUTH REHAB HOSP OF CENTRAL KY	18460	18	21060

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
063030	HEALTHSOUTH REHAB HOSP OF COLORADO SPGS	06200	1720	17820
423026	HEALTHSOUTH REHAB HOSP OF FLORENCE	42200	2655	22500
013029	HEALTHSOUTH REHAB HOSP OF NORTH ALA	01440	3440	26620
103042	HEALTHSOUTH REHAB HOSP OF SPRING HILL	10260	8280	45300
223030	HEALTHSOUTH REHAB HOSP OF WESTERN MA	22070	8003	44140
033029	HEALTHSOUTH REHAB HOSPITAL	03090	8520	46060
103031	HEALTHSOUTH REHAB HOSPITAL	10570	7510	42260
103038	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	10120	5000	33124
453059	HEALTHSOUTH REHAB HOSPITAL OF NORTH HOUSTON	45801	3360	26420
393026	HEALTHSOUTH REHAB HOSPITAL OF READING	39110	6680	39740
103033	HEALTHSOUTH REHAB HOSPITAL OF TALLHASSEE	10360	8240	45220
453054	HEALTHSOUTH REHAB HOSPITAL OF WICHITA FALLS	45960	9080	48660
453031	HEALTHSOUTH REHAB INSTITUTE OF SAN ANTONIO	45130	7240	41700
033028	HEALTHSOUTH REHAB INSTITUTE OF TUCSON	03090	8520	46060
393031	HEALTHSOUTH REHAB OF MECHANICSBURG-ACUTE REHAB	39270	3240	25420
393046	HEALTHSOUTH REHABILITATION HOSPITAL OF ERIE	39320	2360	21500
423028	HEALTHSOUTH REHABILITATION HOSPITAL	42450	1520	16740
443029	HEALTHSOUTH REHABILITATION CENTER OF MEMPHIS	44780	4920	32820
153027	HEALTHSOUTH REHABILITATION HOSP OF KOK	15330	3850	29020
393037	HEALTHSOUTH REHABILITATION HOSP YORK	39800	9280	49620
013030	HEALTHSOUTH REHABILITATION HOSPITAL	01340	2180	20020
043028	HEALTHSOUTH REHABILITATION HOSPITAL	04650	2720	22900
103037	HEALTHSOUTH REHABILITATION HOSPITAL	10510	8280	45300
153029	HEALTHSOUTH REHABILITATION HOSPITAL	15830	8320	45460
303027	HEALTHSOUTH REHABILITATION HOSPITAL	30060	1123	31700
323027	HEALTHSOUTH REHABILITATION HOSPITAL	32000	0200	10740
403025	HEALTHSOUTH REHABILITATION HOSPITAL	40640	7440	41980
443027	HEALTHSOUTH REHABILITATION HOSPITAL	44810	3660	28700
453029	HEALTHSOUTH REHABILITATION HOSPITAL	45610	3360	26420
453048	HEALTHSOUTH REHABILITATION HOSPITAL	45700	0840	13140
443031	HEALTHSOUTH REHABILITATION HOSPITAL-NORTH	44780	4920	32820
193031	HEALTHSOUTH REHABILITATION HOSPITAL OF ALEXANDRIA	19090	3960	29340
453040	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	45910	2800	23104
423025	HEALTHSOUTH REHABILITATION HOSPITAL OF COLUMBIA	42390	1760	17900
043029	HEALTHSOUTH REHABILITATION HOSPITAL OF JONESBORO	04150	3700	27860
293026	HEALTHSOUTH REHABILITATION HOSPITAL OF LAS VEGAS	29010	4120	29820
313029	HEALTHSOUTH REHABILITATION HOSPITAL OF NEW JERSEY	31310	5190	20764
453090	HEALTHSOUTH REHABILITATION HOSPITAL OF ODESSA	45451	5800	36220
393045	HEALTHSOUTH REHABILITATION HOSPITAL OF SEWICKLEY	39010	6280	38300
453053	HEALTHSOUTH REHABILITATION HOSPITAL OF TEXARKANA	45170	8360	45500
453056	HEALTHSOUTH REHABILITATION HOSPITAL OF TYLER	45892	8640	46340
463025	HEALTHSOUTH REHABILITATION HOSPITAL OF UTAH	46170	7160	41620
493028	HEALTHSOUTH REHABILITATION HOSPITAL OF VIRGINIA	49430	6760	40060
013032	HEALTHSOUTH REHABILITATION OF GADSDEN	01270	2880	23460
453057	HEALTHSOUTH REHABILITATION OF MIDLAND ODESSA	45794	5800	33260
293032	HEALTHSOUTH REHABILITIATION HOSPITAL OF HENDERSON	29010	4120	29820
103034	HEALTHSOUTH SEA PINES REHABILITATION HOSPITAL	10050	2680	22744
193085	HEALTHSOUTH SPECIALTY HOSPITAL	19350	5560	35380
45T758	HEALTHSOUTH SPECIALTY HOSPTIAL, INC.	45390	1920	19124
103028	HEALTHSOUTH SUNRISE REHABILITATION HOSPITAL	10050	2680	22744
103032	HEALTHSOUTH TREASURE COAST REHAB HOSPITAL	10300	10	46940
153025	HEALTHSOUTH TRI-STATE REHABILITATION HOSPITAL	15810	2440	21780
053034	HEALTHSOUTH TUSTIN REHABILITATION HOSP	05400	5945	42044
033032	HEALTHSOUTH VALLEY OF THE SUN	03060	6200	38060
513027	HEALTHSOUTH WESTERN HILLS REGIONAL REHAB HOSPITAL	51530	6020	37620
193074	HEALTHWEST REHABILITATION HOSPITAL	19250	5560	35380
26T006	HEARTLAND REGIONAL MEDICAL CENTER	26100	7000	41140
333027	HELEN HAYES HOSPITAL	33620	5600	35644
04T085	HELENA REGIONAL REHABILITATION CENTER	04530	04	04
45T229	HENDRICK CENTER FOR REHABILITATION	45911	0040	10180
49T118	HENRICO DOCTORS HOSPITAL PARHA	49430	6760	40060
23T204	HENRY FORD BI-COUNTY HOSPITAL	23490	2160	47644
23T146	HENRY FORD WYANDOTTE HOSPITAL	23810	2160	19804
05T624	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	05200	4480	31084
34T107	HERITAGE HOSPITAL	34320	6895	40580
45T068	HERMANN HOSPITAL	45610	3360	26420
23T120	HERRICK MEMORIAL HOSPITAL	23450	0440	23

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
14T011	HERRIN HOSPITAL	14990	14	14
34T004	HIGH POINT REGIONAL HOSPITAL	34400	3120	24660
453086	HIGHLANDS REGIONAL REHABILITATION HOS	45480	2320	21340
50T011	HIGHLINE COMMUNITY HOSPITAL	50160	7600	42644
45T101	HILLCREST BAPTIST MEDICAL CENTER	45780	8800	47380
37T001	HILLCREST KAISER REHABILITATION CENTER	37710	8560	46140
363026	HILLSIDE REHABILITATION HOSPITAL	36790	9320	49660
14T122	HINSDALE HOSPITAL—PAULSON REHAB NETWORK	14250	1600	16974
10T225	HOLLYWOOD MEDICAL CENTER	10050	2680	22744
10T073	HOLY CROSS HOSPITAL	10050	2680	22744
14T133	HOLY CROSS HOSPITAL	14141	1600	16974
52T107	HOLY FAMILY MEMORIAL, INC	52350	52	52
36T054	HOLZER MEDICAL CENTER	36270	36	36
45T236	HOPKINS COUNTY MEMORIAL HOSPITAL	45654	45	45
44T046	HORIZON MEDICAL CENTER	44210	5360	34980
33T389	HOSPITAL FOR JOINT DISEASES	33420	5600	35644
07T001	HOSPITAL OF SAINT RAPHAEL	07040	5483	35300
39T111	HOSPITAL OF UNIV OF PENNSYLVANIA	39620	6160	37964
04T076	HOT SPRING COUNTY MEDICAL CENTER	04290	04	04
153039	HOWARD REGIONAL HEALTH SYSTEM-WEST CAMPUS	15330	3850	29020
52T091	HOWARD YOUNG MEDICAL CENTER	52420	52	52
11T200	HUGHSTON ORTHOPEDIC HOSPITAL	11780	1800	17980
05T438	HUNTINGTON MEMORIAL HOSPITAL	05200	4480	31084
23T132	HURLEY MEDICAL CENTER	23240	2640	22420
17T020	HUTCHINSON HOSPITAL CORP.	17770	17	17
133025	IDAHO ELKS REHABILITATION HOSPITAL	13000	1080	14260
13T018	IDAHO REGIONAL MEDICAL CENTER	13090	13	26820
28T081	IMMANUEL REHABILITATION CENTER	28270	5920	36540
26T095	INDEPENDENCE REGIONAL HEALTH CENTER	26470	3760	28140
14T191	INGALLS MEMORIAL HOSPITAL	14141	1600	16974
23T167	INGHAM REGIONAL MEDICAL CENTER	23320	4040	29620
49T122	INOVA REHAB CENTER @ INOVA MOUNT VERNON HOSPITAL	49290	8840	47894
45T132	INPATIENT REHAB	45451	5800	36220
453025	INSTUTUTE FOR REHAB & RESEARCH,THE	45610	3360	26420
37T106	INTEGRIS SOUTHWEST MEDICAL CENTER	37540	5880	36420
323029	INTERFACE INC DBA LIFECOURSE REHAB SERVICES	32220	32	22140
16T082	IOWA METHODIST MEDICAL CENTER	16760	2120	19780
15T024	J.W. SOMMER REHABILIATION UNIT	01160	3480	26900
01T157	JACKSON MEMORIAL HOSPITAL	10120	2650	22520
33T014	JACOBI MEDICAL CENTER	33020	5600	35644
10T022	JAMAICA HOSPITAL MEDICAL CENTER	33590	5000	33124
33T127	JAMESON HOSPITAL	39450	5600	35644
39T016	JANE PHILLIPS MEMORIAL MEDICAL CENTER	37730	39	39
37T018	JEANES HOSPITAL	39620	37	37
39T080	JEANNETTE HOSPITAL	39770	6160	37964
39T010	JEFFERSON REGIONAL MEDICAL CENTER	04340	6280	38300
04T071	JEFFERSON REGIONAL MEDICAL CENTER	39010	6240	38220
39T265	JFK JOHNSON REHAB INSTITUTE	31270	6280	38300
31T108	JIM THORPE REHAB UNIT	37190	5015	20764
37T029	JOHN D. ARCHBOLD MEMORIAL HOSPITAL	11890	37	37
11T038	JOHN HEINZ INST OF REHAB MEDICINE	39680	11	11
393036	JOHN MUIR MEDICAL CENTER	05060	3680	39
05T180	JOHNSON CITY MEDICAL CTR	44890	5775	36084
44T063	JOHNSON REGIONAL REHABILITATION CENTER	04350	3660	27740
04T002	JOHNSTON R. BOWMAN HEALTH CTR.	14141	04	04
14T119	JOINT TOWNSHIP DISTRICT MEMORIAL HOSPITAL, REHABIL	36050	1600	16974
36T032	KADLEC MEDICAL CENTER	50020	4320	36
33T005	KAISER FOUNDATION HOSPITAL-FONTANA REHAB CENTER	05460	1280	15380
50T058	KAISER MEDICAL CENTER	05580	6740	28420
05T140	KALEIDA HEALTH	33240	6780	40140
05T073	KALISPELL REGIONAL MEDICAL CENTER	27140	8720	46700
27T051	KANSAS REHABILITATION HOSPITAL, INC	17880	27	27
173025	KANSAS UNIVERSITY REHAB	17986	8440	45820
17T040	KAPLAN REHABILITATION HOSPITAL	19560	3760	28140
193057	KAWEAH DELTA REHABILITATION HOSPITAL	05640	19	19
05T057	KENMORE MERCY HOSPITAL	33240	8780	47300
33T102	KENT COUNTY MEMORIAL HOSPITAL	41010	1280	15380

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
41T009	KEOKUK AREA HOSPITAL	16550	6483	39300
16T008	KESSLER REHAB	31200	16	16
313025	KESSLER ADVENTIST REHABILITATION HOSPITAL	21150	5640	35084
213029	KETTERING MEDICAL CENTER	36580	8840	13644
36T079	KINGMAN REGIONAL MEDICAL CENTER	03070	2000	19380
03T055	KINGS COUNTY HOSPITAL CENTER	33331	4120	03
33T202	KING'S DAUGHTER MEDICAL CENTER	18090	5600	35644
18T009	KINGSBROOK JEWISH MEDICAL CENTER	33331	3400	26580
33T201	KINGWOOD MEDICAL CENTER	45610	5600	35644
45T775	KOOTENAI MEDICAL CENTER	13270	3360	26420
13T049	LA PALMA INTERCOMMUNITY HOSPITAL	05400	13	17660
05T580	LABETTE COUNTY MEDICAL CENTER	17490	5945	42044
17T120	LAC/RANCHO LOS AMIGOS NATIONAL MED CTR	05400	17	17
05T717	LAFAYETTE GENERAL MEDICAL CENTER	19270	5945	42044
19T002	LAGRANGE COMMUNITY HOSPITAL	15430	3880	29180
15T096	LAKE CHARLES MEMORIAL HOSPITAL	19090	15	15
19T060	LAKE CUMBERLAND REGIONAL HOSP	18972	3960	29340
18T132	LAKE HOSPITAL SYSTEM INC	36440	18	18
36T098	LAKE REGION HEALTHCARE CORPORATION	24550	1680	17460
24T052	LAKELAND HOSPITAL, ST. JOSEPH	23100	24	24
23T021	LAKESHORE CARRAWAY REHABILITATION HOSPITAL	01360	0870	35660
01T064	LAKEWAY REGIONAL HOSPITAL	44310	1000	13820
44T067	LAKEWOOD HOSPITAL	36170	44	34100
36T212	LAKEWOOD REGIONAL MEDICAL CENTER	05200	1680	17460
05T581	LANCASTER COMMUNITY HOSPITAL	05200	4480	31084
05T204	LANCASTER GENERAL HOSP	39440	4480	31084
39T100	LANCASTER REGIONAL MEDICAL CENTER	39440	4000	29540
39T061	LANDER VALLEY MEDICAL CENTER	53060	4000	29540
53T010	LANE FROST HEALTH AND REHABILITATION CENTER	37110	53	53
373032	LANE REHABILTATION CENTER	19160	37	37
19T020	LAPLACE REHABILITATION HOSPITAL	19350	0760	12940
193064	LAPORTE HOSPITAL AND HEALTH SERVICES	15450	5560	35380
45T029	LAREDO MEDICAL CENTER	45953	4080	29700
45T107	LAS PALMAS REHABILITATION HOSP	45480	2320	21340
05T095	LAUREL GROVE HOSPITAL	05000	5775	36084
10T246	LAWNWOOD REGIONAL MEDICAL CENT	10550	2710	38940
07T007	LAWRENCE & MEMORIAL HOSPITAL	07050	5523	35980
17T137	LAWRENCE MEMORIAL HOSPITAL	17220	4150	29940
46T010	LDS HOSPITAL	46170	7160	41620
32T065	LEA REGIONAL MEDICAL CENTER	32120	32	32
49T012	LEE REGIONAL MEDICAL CENTER	49520	49	49
10T084	LEESBURG REGIONAL MEDICAL CENTER	10340	5960	36740
193086	LEESVILLE REHABILITATION HOSPITAL LLC	19570	19	19
38T017	LEGACY GOOD SAMARITAN HOSP & MED CTR	38250	6440	38900
34T027	LENOIR MEMORIAL HOSPITAL REHAB UNIT	34530	34	34
05T060	LEON S. PETERS REHABILITATION	05090	2840	23420
36T086	LEVINE REHABILITATION CENTER	36110	2000	44220
49T048	LEWIS GALE MEDICAL CENTER	49838	6800	40220
15T006	LIBERTY REHABILITATION INSTITUTE	31230	15	33140
31T118	LIMA MEMORIAL HEALTH SYSTEM	36010	3640	35644
36T009	LINCOLN PARK HOSPITAL	14141	4320	30620
14T207	LITTLE COMPANY OF MARY—SAN PEDRO HOSPITAL REHAB	05200	1600	16974
05T078	LIVINGSTON REGIONAL HOSPITAL	44660	4480	31084
44T187	LODI MEMORIAL HOSPITAL	05490	44	44
05T336	LOGAN REGIONAL MEDICAL CENTER	51220	8120	44700
51T048	LOMA LINDA UNIVERSITY MEDICAL CENTER	05460	51	51
05T327	LONG BEACH MEDICAL CENTER	33400	6780	40140
33T225	LONG BEACH MEMORIAL MEDICAL CENTER	05200	5380	35004
05T485	LONG ISLAND COLLEGE HOSPITAL	33331	4480	31084
33T152	LONGVIEW REGIONAL PHYSICAL REHABILITATION	45570	5600	35644
45T702	LOS ROBLES HOSPITAL & MEDICAL CENTER	05660	4420	30980
05T549	LOUIS A. WEISS MEMORIAL HOSPITAL	14141	8735	37100
14T082	LOUISIANA REHABILIATAION HOSPITAL OF MORGAN CITY L	19500	1600	16974
193084	LOURDES	18720	19	19
18T102	LOURDES MEDICAL CENTER	50100	18	18
50R337	LOURDES MEDICAL CENTER	50100	6740	28420
50T023	LOYOLA UNIVERSITY MEDICAL CENTER	14141	6740	28420

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
14T276	LULING REHABILITATION HOSPITAL	19440	1600	16974
193060	LUTHERAN HOSPITAL ACUTE REHAB UNIT	36170	5560	35380
36T087	LUTHERAN MEDICAL CENTER	33331	1680	17460
33T306	MADISON COUNTY HOSPITAL INPATIENT REHAB	36500	5600	35644
45T032	MADONNA REHABILITATION HOSPITAL	28540	4420	45
36T189	MAGEE REHABILITATION HOSPITAL	39620	1840	18140
283025	MAGNOLIA REGIONAL HEALTH CENTER	25010	4360	30700
393038	MAINLAND MEDICAL HOSPITAL	45550	6160	37964
25T009	MARIA PARHAM HEALTHCARE ASSOCIATION, INC.	34900	25	25
45T530	MARIANJOY REHABILITATION HOSPITAL	14250	2920	26420
34T132	MARIETTA MEMORIAL HOSPITAL	36850	34	34
143027	MARLETTE COMMUNITY HOSP CTR FOR REHAB	23750	1600	16974
36T147	MARLTON REHABILITATION HOSPITAL	31150	6020	37620
23T082	MARQUETTE GENERAL HOSPITAL	23510	23	23
313032	MARY BLACK CENTER FOR REHAB	42410	6160	15804
23T054	MARY FREE BED HOSPITAL & REHABILITATION CENTER	23400	23	23
42T083	MARY GREELEY MEDICAL CENTER	16840	3160	43900
233026	MARYVIEW CENTER FOR PHYSICAL REHABILITATION	49711	3000	24340
16T030	MASSILLON COMMUNITY HOSPITAL	36770	16	11180
49T017	MATAGORDA GENERAL HOSPITAL	45790	5720	47260
36T100	MAYO CLINIC HOSPITAL	03060	1320	15940
45T465	MCALESTER REGIONAL HEALTH CENTER	37600	45	
45	MCKAY-DEE HOSPITAL	46280	6200	38060
37T034	MCKEE MEDICAL CENTER	06340	37	37
46T004	MCKENNA REHAB INSTITUTE	45320	7160	36260
06T030	MCLAREN REGIONAL MEDICAL CENTER	23240	2670	22660
45T059	MCO REHAB HOSPITAL	36490	7240	41700
23T141	MEADOWBROOK REHAB HOSPITAL	17450	2640	22420
36T048	MEADOWBROOK REHAB HOSPITAL OF WEST GAB	10120	8400	45780
04T088	MEADOWBROOK REHABILITAION HOSPITAL	45610	04	04
17T180	MEADVILLE MEDICAL CENTER	39260	3760	28140
103036	MECOSTA COUNTY GENERAL HOSPITAL	23530	5000	33124
453052	MED CTR OF LA AT NEW ORLEANS	19350	3360	26420
39T113	MEDCENTER ONE, INC.	35070	39	39
23T093	MEDCENTRAL HEALTH SYSTEM	36710	23	23
19T005	MEDICAL CENTER AT TERRELL	45730	5560	35380
35T015	MEDICAL CENTER OF ARLINGTON	45910	1010	13900
36T118	MEDICAL CENTER OF PLANO	45310	4800	31900
45T683	MEDICAL CENTER OF SOUTH ARKANSAS	04690	1920	19124
45T675	MEDICAL CITY DALLAS HOSPITAL	45390	2800	23104
45T651	MEDICAL CNTR OF DELAWARE	08010	1920	19124
45T647	MEDINA HOSPITAL	33550	1920	19124
08T001	MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER	11220	9160	48864
33T053	MEMORIAL HEALTHCARE CENTER	23770	6840	40380
11T036	MEMORIAL HERMAN BAPTIST HOSP ORANGE	45840	7520	42340
23T121	MEMORIAL HERMANN FT. BEND INPATIENT REHABILITATION	45610	23	23
45T005	MEMORIAL HERMANN NORTHWEST HOSPITAL	45610	0840	13140
45T848	MEMORIAL HOSPITAL	10050	3360	26420
45T184	MEMORIAL HOSPITAL—SOUTH BEND	15700	3360	26420
10T038	MEMORIAL HOSPITAL AT GULFPORT	25230	2680	22744
15T058	MEMORIAL HOSPITAL OF RI	41030	7800	43780
25T019	MEMORIAL MED CENTER OF EAST TE	45020	0920	25060
41T001	MEMORIAL MEDICAL CENTER	14920	6483	39300
45T211	MEMORIAL MEDICAL CENTER—REHABILITATION INSTITUTE	19350	45	45
14T148	MEMORIAL REHABILITATION HOSPITAL	45794	7880	44100
19T135	MENA MEDICAL CENTER	04560	5560	35380
45T133	MENORAH MEDICAL CENTER	17450	5800	33260
04T015	MERCY FITZGERALD HOSPITAL	39290	04	04
17T182	MERCY FRANCISCAN HOSPITAL MT. AIRY	36310	3760	28140
39T156	MERCY FRANCISCAN HOSPITAL WESTERN HILLS	36310	6160	37964
36T234	MERCY GENERAL HEALTH PARTNERS	23600	1640	17140
36T113	MERCY GENERAL HOSPITAL	05440	1640	17140
23T004	MERCY HEALTH CENTER	17800	3000	34740
05T017	MERCY HEALTH CENTER, INC	37540	6920	40900
17T142	MERCY HEALTH SYSTEM CORP	52520	17	17
37T013	MERCY HEALTH SYSTEM OF KANSAS	17050	5880	36420
52T066	MERCY HOSPITAL	10120	3620	27500

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
17T058	MERCY HOSPITAL	14141	17	17
10T061	MERCY HOSPITAL OF PITTSBURGH	39010	5000	33124
14T158	MERCY HOSPITAL PORT HURON	23730	1600	16974
39T028	MERCY HOSPITAL REHABILITATION UNIT	34590	6280	38300
23T031	MERCY MEDICAL	01010	2160	47644
34T098	MERCY MEDICAL CENTER	33400	1520	16740
013027	MERCY MEDICAL CENTER	36770	5160	01
33T259	MERCY MEDICAL CENTER	52690	5380	35004
36T070	MERCY MEDICAL CENTER-DES MOINES	16760	1320	15940
52T048	MERCY MEDICAL CENTER-DUBUQUE	16300	0460	36780
16T083	MERCY MEDICAL CENTER-SIOUX CITY	16960	2120	19780
16T069	MERCY MEDICAL CENTER-NORTH IOWA	16160	2200	20220
16T153	MERCY MEMORIAL HEALTH CENTER	37090	7720	43580
16T064	MERCY PROVIDENCE HOSPITAL	39010	16	16
37T047	MERIDIA EUCLID HOSPITAL	36170	37	37
39T136	MERITCARE HEALTH SYSTEM	35080	6280	38300
36T082	MERITER HOSPITAL INC.	52120	1680	17460
35T011	MERWICK REHAB HOSPITAL	31260	2520	22020
52T089	MESA GENERAL HOSPITAL	03060	4720	31540
31T010	MESA LUTHERAN HOSPITAL REHAB	03060	8480	45940
03T017	MESQUITE COMMUNITY HOSPITAL	45390	6200	38060
03T018	METHODIST HOSPITAL	19350	6200	38060
45T688	METHODIST HOSPITAL	19350	1920	19124
19T124	METHODIST HOSPITAL	24260	5560	35380
19T200	METHODIST HOSPITAL OF SOUTHERN CA	05200	5560	35380
24T053	METHODIST HOSPITAL REHABILITATION CENTER	18500	5120	33460
05T238	METHODIST HOSPITAL, THE	45610	4480	31084
18T056	METHODIST MEDICAL CENTER	45390	2440	21780
45T358	METHODIST MEDICAL CENTER OF ILLINOIS	14800	3360	26420
45T051	METHODIST NORTHLAKE	15440	1920	19124
14T209	METHODIST SPECIALTY/TRANSPLANT	45130	6120	37900
15T002	METROHEALTH MEDICAL CENTER	36170	2960	23844
45T631	METROPOLITAN HOSPITAL	33420	7240	41700
36T059	METROPOLITAN HOSPITAL AND METRO HEALTH CORPORATION	23400	1680	17460
33T199	METROPOLITAN METHODIST HOSP	45130	5600	35644
23T236	MI LAND E. KNAPP REHABILITATION CENTER	24260	3000	24340
45T388	MIAMI VALLEY HOSPITAL	36580	7240	41700
24T004	MICHAEL REESE HOSPITAL	14141	5120	33460
36T051	MID AMERICA REHABILITATION HOSPITAL	17450	2000	19380
14T075	MID JEFFERSON HOSPITAL	45700	1600	16974
173026	MIDDLETOWN REGIONAL HOSPITAL	36080	3760	28140
45T514	MILLER DWAN MEDICAL CENTER	24680	0840	13140
36T076	MILLS HEALTH CENTER	05510	3200	17140
24T019	MILTON S HERSHEY MEDICAL CENTER	39280	2240	20260
05T007	MINDEN MEDICAL CENTER REHAB	19590	7360	41884
39T256	MISSION HOSPITAL	05400	3240	25420
19T144	MISSION HOSPITAL	45650	7680	19
05T567	MISSISSIPPI METHODIST REHABILITATION CENTER	25240	5945	42044
45T176	MISSISSIPPI METHODIST REHABILITATION CENTER	25240	4880	32580
253025	MISSOURI BAPTIST MEDICAL CENTER	26940	3560	27140
25T152	MISSOURI DELTA MEDICAL CENTER	26982	3560	27140
26T108	MOBILE INFIRMARY	01480	7040	41180
26T113	MODESTO REHABILITATION HOSPITAL	05600	26	26
01T113	MONONGAHELA VALLEY HOSPITAL	39750	5160	33660
053036	MONTEFIORE MEDICAL CENTER	33020	5170	33700
39T147	MORGAN HOSPITAL & MEDICAL CTR	15540	6280	38300
33T059	MORTON PLANT NORTH BAY HOSPITAL	10500	5600	35644
15T038	MOSES CONE HEALTH SYSTEM	34400	3480	26900
34T091	MOSS REHAB	39620	3120	24660
39T142	MOUNT CARMEL REGIONAL MEDICAL CENTER	17180	6160	37964
17T006	MOUNT SINAI MEDICAL CENTER	10120	17	17
10T034	MOUNTAINVIEW REGIONAL MEDICAL CENTER	32060	5000	33124
32T085	MT CARMEL INPATIENT REHAB UNIT	36250	4100	29740
36T035	MT SINAI HOSPITAL	33420	1840	18140
33T024	MUNSON MEDICAL CENTER	23270	5600	35644
23T097	MUSKOGEE REGIONAL REHABILITATION CENTER	37500	23	23
37T025	NACOGDOCHES COUNTY HOSPITAL DISTRICT	45810	37	37

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
45T508	NAPLES COMMUNITY HOSPITAL, INC.	10100	45	45
10T018	NASHVILLE REHABILITATION HOSPITAL	44180	5345	34940
44T026	NASSAU UNIVERSITY MEDICAL CENTER	33400	5360	34980
33T027	NATCHEZ REGIONAL MEDICAL CENTER	25000	5380	35004
25T084	NATIONAL PARK	04250	25	25
04T078	NATIONAL REHABILITATION HOSPITAL	09000	04	26300
093025	NAVARRO REGIONAL HOSPITAL	45820	8840	47894
45T447	NAZARETH HOSPITAL	39620	45	45
39T204	NEBRASKA METHODIST HEALTH SYSTEM	28270	6160	37964
28T040	NEW ENGLAND REHAB HOSPITAL OF PORTLAND	20020	5920	36540
203025	NEW ENGLAND REHABILITAION HOSPITAL-WOBURN	22090	6403	38860
223026	NEW HANOVER REGIONAL MEDICAL CENTER	34640	1123	15764
34T141	NEW MEXICO REHABILITATION CENTER	32020	9200	48900
323026	NEW ORLEANS EAST REHABILITATION	19350	32	32
193089	NEW YORK METHODIST HOSPITAL	33331	5560	35380
33T236	NEW YORK PRESBYTERIAN HOSPITAL	33420	5600	35644
33T101	NEWMAN REGIONAL HEALTH	17550	5600	35644
17T001	NEWPORT HOSPITAL	41020	17	17
41T006	NEWTON MEDICAL CENTER	17390	6483	39300
17T103	NEWTON MEMORIAL HOSPITAL	31360	9040	48620
31T028	NEXT STEP ACUTE REHABILITATION CENTER	39190	5640	35084
39T194	NIX HEALTH CARE SYSTEM	45130	0240	10900
45T130	NOBLE HOSPITAL REHAB UNIT	22070	7240	41700
10T063	NORMAN REGIONAL HOSPITAL	37130	8280	45300
22T065	NORTH AUSTIN MEDICAL CENTER	45940	8003	44140
37T008	NORTH BROWARD MEDICAL CENTER	10050	5880	36420
45T809	NORTH CAROLINA BAPTIST HOSPITALS	34330	0640	12420
10T086	NORTH CENTRAL MEDICAL CENTER	45310	2680	22744
34T047	NORTH COLORADO MEDICAL CENTER	06610	3120	49180
45T403	NORTH COUNTRY REGIONAL HOSPITAL	24030	1920	19124
06T001	NORTH DALLAS REHABILITATION HOSPITAL	45620	3060	24540
24T100	NORTH DALLAS REHABILITATION HOSPITAL	45390	24	24
453032	NORTH FULTON REGIONAL HOSPITAL	11470	1920	19124
11T198	NORTH HILLS HOSPITAL	45910	0520	12060
45T087	NORTH KANSAS CITY HOSPITAL	26230	2800	23104
26T096	NORTH MEMORIAL HEALTH CENTER	24260	3760	28140
24T001	NORTH MISS. MEDICAL CENTER	25400	5120	33460
25T004	NORTH MONROE MEDICAL CENTER	19360	25	25
19T197	NORTH OAKLAND MEDICAL CENTERS	23620	5200	33740
23T013	NORTH OAKS REHAB HOSP INC	19520	2160	47644
193044	NORTH SHORE REGIONAL MEDICAL CENTER	19510	19	19
19T204	NORTH SHORE UNIVERSITY HOSPITAL @ GLEN COVE	33400	5560	35380
33T181	NORTH SUBURBAN MEDICAL CENTER	06000	5380	35004
06T065	NORTHEAST GEORGIA MEDICAL CENTER	11550	2080	19740
11T029	NORTHEAST METHODIST HOSPITAL	45130	11	23580
45T733	NORTHEAST OKLAHOMA REHABILITATION ASSOCIATES, LP	37710	7240	41700
373029	NORTHEAST REGIONAL MEDICAL CENTER	26000	8560	46140
26T022	NORTHEAST REHABILITATION HOSPITAL	30070	26	26
303026	NORTHERN CALIFORNIA REHABILITATION HOSPITAL	05550	1123	40484
05T699	NORTHERN ILLINOIS MEDICAL CENTER	14640	6690	39820
14T116	NORTHERN MICHIGAN HOSPITAL	23230	1600	16974
23T105	NORTHERN NEVADA MEDICAL CENTER	29150	23	23
29T032	NORTHLAKE MEDICAL CENTER	11370	6720	39900
11T033	NORTHPORT MEDICAL CENTER	01620	0520	12060
01T145	NORTHRIDGE HOSPITAL MEDICAL CENTER	05200	8600	46220
05T116	NORTHWEST HEALTH SYSTEM	04710	4480	31084
04T022	NORTHWEST HOSPITAL	50160	2580	22220
50T001	NORTHWEST MISSISSIPPI REGIONAL MED CTR	25130	7600	42644
25T042	NORTHWEST REGIONAL HOSPITAL	45830	25	25
45T131	NORWALK HOSPITAL ASSOCIATION	07000	1880	18580
07T034	OAK FOREST HOSPITAL	14141	5483	14860
14T301	OAKLAND REGIONAL HOSPITAL	23620	1600	16974
233028	OAKWOOD HERITAGE HOSPITAL	23810	2160	47644
23T270	OCHSNER REHABILITATION CENTER	19250	2160	19804
19T036	OGDEN REGIONAL MEDICAL CENTER	46280	5560	35380
46T005	OHIO STATE UNIVERSITY HOSPITAL	36250	7160	36260
36T085	OHIO VALLEY GENERAL HOSPITAL ARU	39010	1840	18140

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
39T157	OM	18290	6280	38300
18T038	OPELOUSAS GENERAL HOSPITAL	19480	5990	36980
19T017	ORANGE REGIONAL MEDICAL CENTER	33540	3880	19
33T001	ORANGE REGIONAL MEDICAL CENTER	33540	5660	39100
33T126	OREGON REHABILITATION CENTER	38190	5660	39100
38T033	ORLANDO REGIONAL HEALTHCARE-CMR	10470	2400	21660
10T006	OSTEOPATHIC MEDICAL CENTER OF TEXAS	45910	5960	36740
45T121	OU MEDICAL CENTER	37540	2800	23104
37T093	OUR LADY OF LOURDES MEDICAL CENTER	31160	5880	36420
31T029	OUR LADY OF LOURDES REG MED CENTER	19270	6160	15804
19T102	OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER	19160	3880	29180
19T064	OVERLAKE HOSPITAL MEDICAL CENTER	50160	0760	12940
50T051	PALESTINE REGIONAL REHAB HOSPITAL	45000	7600	42644
45T113	PALMYRA MEDICAL CENTER	11390	45	45
11T163	PALOMAR MEDICAL CENTER	05470	0120	10500
05T115	PAMPA REGIONAL MEDICAL CENTER	45563	7320	41740
45T099	PARADISE VALLEY HOSPITAL	05470	45	45
05T024	PARIS REGIONAL MEDICAL CENTER	45750	7320	41740
45T196	PARK PLACE MEDICAL CENTER	45700	45	45
45T518	PARK PLAZA HOSPITAL	45610	0840	13140
45T659	PARKLAND HEALTH AND HOSPITAL SYSTEM	45390	3360	26420
45T015	PARKRIDGE MEDICAL CENTER	44320	1920	19124
44T156	PARKVIEW HOSPITAL	15010	1560	16860
15T021	PARKVIEW MEDICAL CENTER	06500	2760	23060
06T020	PARKVIEW REGIONAL HOSPITAL	45758	6560	39380
45T400	PARKWAY REGIONAL MEDICAL CENTER	10120	45	45
10T114	PARMA COMMUNITY GENERAL HOSPITAL	36170	5000	33124
36T041	PATRICIA NEAL REHABILITATION CENTER	44460	1680	17460
44T125	PENINSULA HOSPITAL CENTER	33590	3840	28940
33T002	PENNYSLVANIA HOSPITAL, ACUTE REHABILITATION UNIT	39620	5600	35644
39T226	PENROSE HOSPITAL/ELEANOR-CAPRON	06200	6160	37964
06T031	PETERSON REHABILITATION HOSPITAL AND GERIATIC CEN	51340	1720	17820
513025	PHELPS COUNTY REGIONAL MED CENTER	26800	9000	48540
26T017	PHELPS MEMORIAL HOSPITAL	33800	26	26
33T261	PHOEBE PUTNEY	11390	5600	35644
11T007	PHOENIX BAPTIST HOSPITAL	03060	0120	10500
03T030	PHYSICAL REHABILITAITON UNIT AT OTTUMWA REGIONAL H	16890	6200	38060
16T089	PIEDMONT HOSPITAL	11470	16	16
11T083	PIKEVILLE METHODIST REHABILITATION HOSPITAL	18970	0520	12060
18T044	PINECREST REHABILITATION HOSPITAL	10490	18	18
103030	PINNACLE REHAB	37540	8960	48424
373025	PINNACLEHEALTH HOSPITALS	39280	5880	36420
39T067	PITT COUNTY MEMORIAL HOSPITAL	34730	3240	25420
34T040	PLAZA MEDICAL CENTER	45910	3150	24780
45T672	POPLAR BLUFF REGIONAL MEDICAL CENTER	26110	2800	23104
26T119	PORTER ADVENTIST HOSPITAL	06150	26	26
06T064	PORTNEUF MEDICAL CENTER	13020	2080	19740
13T028	POTTSTOWN MEMORIAL MEDICAL CENTER	39560	6340	38540
39T123	POTTSVILLE HOSPITAL-WARNE CLINIC	39650	6160	37964
39T030	POUDRE VALLEY HEALTH CARE INC	06340	39	39
06T010	PREMIER REHABILITATION HOSPITAL	19360	2670	22660
14T007	PRESBYTERIAN HOSPITAL OF DALLAS	45390	1600	16974
193082	PRESBYTERIAN INTERCOMMUNITY HOSPITAL	05200	5200	33740
45T462	PROVENA COVENANT MEDICAL CENTER REHAB	14090	1920	19124
05T169	PROVENA SAINT JOSEPH HOSPITAL	14530	4480	31084
14T113	PROVENA ST. JOSEPH MEDICAL CENTER	14989	1400	16580
14T217	PROVIDENCE ALASKA MEDICAL CENTER	02020	1600	16974
02T001	PROVIDENCE CENTRALIA HOSPITAL	50200	0380	11260
50T019	PROVIDENCE EVERETT MEDICAL CENTER	50300	50	50
50T014	PROVIDENCE HOLY CROSS MEDICAL CENTER	05200	7600	42644
05T278	PROVIDENCE HOSPITAL	23620	4480	31084
23T019	PROVIDENCE MEDFORD MEDICAL CENTER	38140	2160	47644
38T075	PROVIDENCE PORTLAND MEDICAL CENTER	38250	4890	32780
38T061	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	05200	6440	38900
05T235	PROVIDENCE ST. PETER HOSPITAL	50330	4480	31084
50T024	QUEEN OF ANGELS-HOLLYWOOD PRESBYTERIAN MEDICAL C	05200	5910	36500
05T063	QUEEN OF THE VALLEY HOSPITAL	05380	4480	31084

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
05T009	QUEENS HOSPITAL CENTER	33590	8720	34900
33T231	RANCHO REHABILITATION	29010	5600	35644
29T007	RAPID CITY REGIONAL HOSPITAL	43510	4120	29820
43T077	REBSAMEN MEDICAL CENTER	04590	6660	39660
04T074	REDMOND REHABILITATION CENTER	11460	4400	30780
11T168	REGIONAL MEDICAL CENTER	18530	11	40660
18T093	REGIONAL REHAB CENTER AT HUGH CHATHAM	34850	18	18
34T097	REGIONAL REHAB CENTER OF NORTON COMMUNITY HOSPITAL	49661	34	34
49T001	REGIONAL REHABILITATION CENTER	42280	49	49
42T036	REGIONAL REHABILITATION HOSPITAL	01500	42	42
013033	REGIONS HOSPITAL REHAB INSTITUTE	24610	5240	33860
24T106	REHAB CARE CENTER AT INDIANA REGIONAL MEDICAL CTR	39390	5120	33460
39T173	REHAB CENTER OF MARION	36520	39	39
36T011	REHAB HOSP OF R I	41030	36	36
413025	REHAB HOSP OF THE CAPE AND ISLANDS	22000	6483	39300
223032	REHAB HOSPITAL OF BATON ROUGE	19160	0743	12700
193028	REHAB INSTITUTE AT SANTA BARBARA,THE	05520	0760	12940
053028	REHAB INSTITUTE AT TCMC	44180	7480	42060
44T135	REHAB MEDICINE ST. MARY'S ATHENS	11260	5360	34980
11T006	REHAB UNIT OF PACIFIC ALLIANCE MEDICAL CENTER	05200	0500	12020
05T018	REHABCARE CENTER AT HOSPITAL DR. PILA	40560	4480	31084
40T003	REHABILITATION CENTER AT LAFAYETTE HOME HOSPITAL	15780	6360	38660
15T109	REHABILITATION CENTER OF NORTHERN ARIZONA	03020	3920	29140
03T023	REHABILITATION HOSPITAL	15010	2620	22380
153030	REHABILITATION HOSPITAL OF CONNECTICUT,THE	07010	2760	23060
073025	REHABILITATION HOSPITAL OF INDIANA	15480	3283	25540
153028	REHABILITATION HOSPITAL OF INDIANA AT ST VINCENT	15480	3480	26900
153038	REHABILITATION HOSPITAL OF MEMPHIS	44780	3480	26900
44T152	REHABILITATION HOSPITAL OF NEW MEXICO	32000	4920	32820
323028	REHABILITATION HOSPITAL OF SOUTH JERSEY	31190	0200	10740
313036	REHABILITATION HOSPITAL OF THE PACIFIC	12020	8760	47220
123025	REHABILITATION HOSPITAL OF TINTON FALLS	31290	3320	26180
313035	REHABILITATION INSTITUTE AT MORRISTOWN MEMORIAL	31300	5190	20764
31T015	REHABILITATION INSTITUTE OF CHICAGO	14141	5640	35084
143026	REHABILITATION INSTITUTE OF MCALLEN	45650	1600	16974
45T811	REHABILITATION INSTITUTE OF MICHIGAN	23810	4880	32580
233027	REHABILITATION INSTITUTE OF ST LOUIS, THE	26940	2160	19804
263028	REHABILITATION PATIENT CARE UNIT	06200	7040	41180
06T022	REID HOSP-ACUTE REHAB UNIT	15880	1720	17820
15T048	RENO REHAB ASSOCIATES, LIMITED PARTNERSHIP	29150	15	15
293027	RESEARCH MEDICAL CENTER	26070	6720	39900
26T027	RESURRECTION MEDICAL CENTER	14141	26	26
14T117	RHD MEMORIAL MEDICAL CENTER	45390	1600	16974
45T379	RICHLAND PARISH REHABILITATION HOSPITA	19410	1920	19124
193075	RILEY MEMORIAL HOSPITAL	25370	19	19
25T081	RIO VISTA REHAB HOSPITAL	45480	25	25
453033	RIVER PARK HOSPITAL	44880	2320	21340
44T151	RIVER REGION HEALTH SYSTEM	25740	44	44
25T031	RIVER WEST MEDICAL CENTER	19230	25	25
19T131	RIVERSIDE MEDICAL CENTER	14540	19	12940
14T186	RIVERSIDE REHAB INSTITUTE	49622	3740	28100
493027	RIVERVIEW HOSPITAL	15280	5720	47260
15T059	RIVERVIEW MEDICAL CENTER	31290	3480	26900
31T034	ROCHESTER GENERAL HOSPITAL	33370	5190	20764
33T125	ROGER C. PEACE	42220	6840	40380
42T078	ROGERS CITY REHABILITATION HOSPITAL	23700	3160	24860
233029	ROME MEMORIAL HOSPITAL	33510	23	23
33T215	ROPER REHABILITATION HOSPITAL	42090	8680	46540
42T087	ROWAN REGIONAL MEDICAL CENTER	34790	1440	16700
34T015	ROXBOROUGH	39620	1520	34
39T304	RUSH OAK PARK HOSPITAL	14141	6160	37964
14T063	RUSH-COPLEY MEDICAL CENTER	14530	1600	16974
14T029	RUSK INSTITUTE	33420	1600	16974
33T214	RUSK REHABILITATION CENTER LLC	26090	5600	35644
263027	RUTLAND REGIONAL MEDICAL CENTER	47100	1740	17860
47T005	SACRED HEART HOSPITAL	52170	47	47
52T013	SACRED HEART REHAB INST	52390	2290	20740

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
523025	SADDLEBACK MEMORIAL MEDICAL CENTER	05400	5080	33340
05T603	SAGE REHAB INSTITUTE	19160	5945	42044
193078	SAINT ALPHONSUS REGIONAL MEDICAL CENTER	13000	0760	12940
13T007	SAINT ANTHONY'S HEALTH CENTER	14680	1080	14260
14T052	SAINT FRANCIS HOSPITAL	31230	7040	41180
313037	SAINT FRANCIS HOSPITAL	33230	3640	35644
33T067	SAINT FRANCIS HOSPITAL	44780	2281	39100
44T183	SAINT FRANCIS MEDICAL CENTER	14800	4920	32820
14T067	SAINT FRANCIS MEMORIAL HOSPITAL	05480	6120	37900
05T152	SAINT JOHNS MERCY MEDICAL CENTER	26940	7360	41884
26T020	SAINT JOSEPH HEALTH CENTER	26470	7040	41180
26T085	SAINT JOSEPH HOSPITAL	14141	3760	28140
14T224	SAINT JOSEPH REGIONAL MEDICAL CENTER	15700	1600	16974
15T012	SAINT LUKE'S SOUTH HOSPITAL	17450	7800	43780
17T185	SAINT MARY OF NAZARETH HOSPITAL	14141	3760	28140
14T180	SAINT MARYS REGIONAL MEDICAL CENTER	29150	1600	16974
29T009	SAINT VINCENT CATHOLIC MEDICAL CENTERS OF NEW YORK	33420	6720	39900
33T290	SAINT VINCENT HEALTH CENTER	39320	5600	35644
39T009	SALEM HOSPITAL REGIONAL REHABILITATION CENTER	38230	2360	21500
38T051	SALINA REGIONAL HEALTH CENTER	17840	7080	41420
17T012	SALINE MEMORIAL HOSPITAL	04620	17	17
04T084	SALT LAKE REGIONAL MEDICAL CENTER	46170	4400	30780
46T003	SAM KARAS ACUTE REHAB AT NATIVIDAD MEDICAL CENTER	05370	7160	41620
05T248	SAMARITAN MEDICAL CENTER	33330	7120	41500
33T157	SAN ANGELO COMMUNITY MEDICAL CENTER	45930	33	33
45T340	SAN ANTONIO WARM SRPINGS REHABILITATION HOSPITAL	45130	7200	41660
453035	SAN CLEMENTE HOSPITAL	05400	7240	41700
05T585	SAN JACINTO METHODIST HOSPITAL	45610	5945	42044
45T424	SAN JOAQUIN GENERAL HOSPITAL	05490	3360	26420
05T167	SAN JOAQUIN VALLEY REHABILITATION HOSP	05090	8120	44700
053032	SAN JOSE MEDICAL CENTER	05530	2840	23420
05T215	SAN LUIS VALLEY REGIONAL MEDICAL CENTER	06010	7400	41940
06T008	SANTA CLARA VALLEY MEDICAL CENTER	05530	06	06
05T038	SANTA ROSA MEMORIAL HOSPITAL	05590	7400	41940
05T174	SARASOTA MEMORIAL HOSPITAL	10570	7500	42220
10T087	SATILLA REGIONAL REHABILITATION INSTITUTE	11940	7510	42260
11T003	SAVOY MEDICAL CENTER	19190	11	11
19T025	SCHWAB REHABILITATION HOSPITAL	14141	19	19
143025	SCOTT & WHITE	45120	1600	16974
45T054	SCOTTSDALE HEALTHCARE INPATIENT REHAB	03060	3810	28660
03T038	SCRIPPS MEMORIAL HOSPITAL ENCINITAS	05470	6200	38060
05T503	SENTARA NORFOLK GENERAL HOSPITAL	49641	7320	41740
49T007	SEWICKLEY VALLEY HOSPITAL	39010	5720	47260
39T037	SHANDS REHAB HOSPITAL	10000	6280	38300
10T113	SHANNON WEST TEXAS MEMORIAL HOSPITAL	45930	2900	23540
45T571	SHARON REGIONAL HEALTH SYSTEM	39530	7200	41660
39T211	SHARP MEMORIAL REHABILITATION CENTER	05470	7610	49660
05T100	SHELTERING ARMS REHABILITATION HOSPITAL	49430	7320	41740
493025	SHORE REHABILITATION INSTITUTE	31310	6760	40060
313033	SHREVEPORT REHABILITATION HOSPITAL	19080	5190	20764
193083	SID PETERSON MEMORIAL HOSPITAL	45734	7680	43340
45T007	SIERRA VISTA REGIONAL MEDICAL CENTER	05500	45	45
05T506	SILVER CROSS HOSPITAL	14989	7460	42020
14T213	SIMI VALLEY HOSPITAL & HEALTH CARE SVC	05660	1600	16974
05T236	SINAI-GRACE HOSPITAL	23810	8735	37100
23T024	SINGING RIVER HOSPITAL	25290	2160	19804
25T040	SIOUX VALLEY HOSPITAL	43490	0920	37700
43T027	SISKIN HOSPITAL FOR PHYSICAL REHABILITATION	44320	7760	43620
443025	SISTER KENNY REHAB INSTITUTE—ABBOTT NORTHWESTERN	24260	1560	16860
24T057	SISTER KENNY REHAB INSTITUTE—UNITED HOSPITAL	24610	5120	33460
24T038	SKYLINE REHABILITATION CENTER	44180	5120	33460
44T006	SLIDELL MEMORIAL HOSPITAL	19510	5360	34980
19T040	SOUTH FULTON	11470	5560	35380
11T219	SOUTH GEORGIA MEDICAL CENTER	11700	0520	12060
11T122	SOUTH MIAMI HOSPITAL PHYSICAL MEDICINE & REHAB	10120	11	46660
10T154	SOUTH POINTE HOSPITAL	36170	5000	33124
36T144	SOUTH TEXAS REGIONAL SPECIALTY HOSPITAL	45060	1680	17460

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
45T165	SOUTHCOAST HOSPITALS GROUP, INC.	22150	45	41700
22T074	SOUTHEAST MISSOURI HOSPITAL	26150	1123	14484
26T110	SOUTHEASTERN REGIONAL REHABILITATION CENTER	34250	26	26
34T028	SOUTHERN HILLS REGIONAL REHAB	51270	2560	22180
513026	SOUTHERN INDIANA REHABILITATION HOSPITAL	15210	51	51
153037	SOUTHERN KENTUCKY REHABILITATION HOSPITAL	18986	4520	31140
183029	SOUTHERN OHIO MEDICAL CENTER	36740	18	14540
36T008	SOUTHERN TENNESSEE MEDICAL CENTER	44250	36	36
44T058	SOUTHSIDE HOSPITAL	33700	44	44
33T043	SOUTHWEST GENERAL HOSPITAL	45130	5380	35004
45T697	SOUTHWEST MEDICAL CENTER	19270	7240	41700
19T205	SOUTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER	25560	3880	29180
25T097	SOUTHWEST WASHINGTON MEDICAL CENTER	50050	25	25
50T050	SOUTHWESTERN MEDICAL CENTER	37540	6440	38900
37T097	SOUTHWESTERN REHABILITATION HOSPITAL	23120	5880	36420
233025	SPAIN REHABILITATION CENTER	01360	3720	12980
01T033	SPALDING REHABILITATION HOSPITAL	06150	1000	13820
063027	SPRING BRANCH MEDICAL CENTER	45610	2080	19740
45T630	SSM DEPAUL HEALTH CENTER	26940	3360	26420
26T104	SSM REHABILITATION INSTITUTE	26940	7040	41180
263025	SSM ST. JOSEPH KIRKWOOD	26940	7040	41180
26T081	ST. FRANCIS MEDICAL CTR	19360	7040	41180
04T007	ST. AGNES MEDICAL CENTER	39620	4400	30780
19T125	ST. ALEXIUS MEDICAL CENTER	35070	5200	33740
39T022	ST. ANTHONYS MEDICAL CENTER	26940	6160	37964
35T002	ST. ANTHONY'S REHABILITATION HOSPITAL	10050	1010	13900
26T077	ST. CATHERINE'S REHABILITATION HOSPITAL	10120	7040	41180
103027	ST. DAVIDS REHABILITATION CENTER	45940	2680	22744
103026	ST. EDWARD MERCY MEDICAL CENTER	04650	5000	33124
453038	ST. ELIZABETH HEALTH CENTER	36510	0640	12420
04T062	ST. FRANCIS MEDICAL CENTER	26260	2720	22900
36T064	ST. JOHN DETROIT RIVERVIEW HOSP	23810	9320	49660
26T183	ST. JOHN MACOMB HOSPITAL	23490	26	26
23T119	ST. JOHN MEDICAL CENTER, INC.	37710	2160	19804
23T195	ST. JOHN NORTH SHORES HOSPITAL	23490	2160	47644
37T114	ST. JOHNS REGIONAL MEDICAL CENTER	26480	8560	46140
23T257	ST. JOHN'S REGIONAL MEDICAL CENTER	05660	2160	47644
26T001	ST. JOHN'S REHABILITATION HOSPITAL	19250	3710	27900
05T082	ST. JOSEPH HEALTH SERVICES OF RI	41030	8735	37100
193061	ST. JOSEPH HOSPITAL	05110	5560	35380
41T005	ST. JOSEPH HOSPITAL	30050	6483	39300
05T006	ST. JOSEPH HOSPITAL & HEALTH CENTER	15330	05	05
30T011	ST. JOSEPH REGIONAL REHAB	45190	1123	31700
15T010	ST. JOSEPHS HOSPITAL	52390	3850	29020
45T011	ST. JOSEPH'S MERCY HEALTH CENTER	04250	1260	17780
52T136	ST. LAWRENCE REHABILITATION CENTER	31260	5080	33340
04T026	ST. LUKES EPISCOPAL HOSPTIAL	45610	04	26300
313027	ST. LUKES HOSPITAL OF KANSAS CITY	26470	8480	45940
45T193	ST. LUKES NORTHLAND HOSPITAL	26230	3360	26420
26T138	ST. LUKE'S REHABILITATION HOSPITAL OF LAFAYETTE	19270	3760	28140
26T062	ST. LUKES REHABILITATION INSTITUTE	50310	3760	28140
193087	ST. MARGARET MERCY HLTHCARE CTRS	15440	3880	29180
503025	ST. MARY MEDICAL CENTER	05200	7840	44060
15T004	ST. MARY MEDICAL CENTER	50350	2960	23844
05T191	ST. MARY-CORWIN MEDICAL CENTER	06500	4480	31084
50T002	ST. MARYS HOSPITAL	24540	50	50
06T012	ST. MARY'S HOSPITAL BLUE SPRINGS	26470	6560	39380
24T010	ST. MARYS MEDICAL CENTER	15810	6820	40340
26T193	ST. MARYS MEDICAL CENTER	44460	3760	28140
15T100	ST. MARY'S MEDICAL CENTER	05480	2440	21780
44T120	ST. MARY'S WEST PALM BEACH	10120	3840	28940
05T457	ST. NICHOLAS HOSPITAL	52580	7360	41884
10T288	ST. PAUL HOSPITAL	45390	5000	33124
52T044	ST. VINCENT HEALTHCARE	27550	7620	43100
45T044	ST. VINCENT HOSPITAL	32240	1920	19124
27T049	ST. VINCENT HOSPITAL	52040	0880	13740
32T002	ST. VINCENT REHAB HOSP IN PART HLTHSOUT	04590	7490	42140

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
52T075	ST. AGNES HOSPITAL	52190	3080	24580
043031	ST. ALEXIUS HOSPITAL	26940	4400	30780
52T088	ST. ANTHONY HOSPITAL REHAB CENTER	37540	52	22540
26T210	ST. ANTHONY MEDICAL CENTER	15440	7040	41180
37T037	ST. ANTHONY MEMORIAL HEALTH CENTERS	15450	5880	36420
15T126	ST. CHARLES HOSPITAL AND REHABILITATION CENTER	33700	2960	23844
15T015	ST. CHARLES MERCY HOSPITAL	36490	15	33140
33T246	ST. CLAIR HOSPITAL	39010	5380	35004
36T081	ST. CLAIRE MC	18975	8400	45780
39T228	ST. CLOUD HOSPITAL	24720	6280	38300
18T018	ST. ELIZABETH HOSPITAL	52430	18	18
24T036	ST. ELIZABETH HOSPITAL REHAB	14900	6980	41060
52T009	ST. FRANCIS HOSPITAL REHAB	08010	0460	11540
14T187	ST. JAMES HOSPITAL AND HEALTH CENTERS	14141	7040	41180
08T003	ST. JOHN NORTHEAST COMMUNITY HOSPITAL	23810	9160	48864
14T172	ST. JOHNS REGIONAL HEALTH CENTER	26380	1600	16974
23T065	ST. JOSEPH HOSPITAL	50360	2160	19804
26T065	ST. JOSEPH MEDICAL CENTER	50260	7920	44180
50T030	ST. JOSEPH MERCY HOSPITAL-ANN ARBOR	23800	0860	13380
50T108	ST. JOSEPHS HOSPITAL	03060	8200	45104
23T156	ST. JOSEPH'S HOSPITAL	33070	0440	11460
03T024	ST. JOSEPH'S HOSPITAL	52700	6200	38060
33T108	ST. JOSEPH'S MERCY OF MACOMB	23490	2335	21300
52T037	ST. JOSEPH'S WAYNE HOSPITAL	31320	52	52
23T047	ST. JUDE MEDICAL CENTER	05400	2160	47644
31T116	ST. LUKE'S	24680	0875	35644
05T168	ST. LUKE'S/ROOSEVELT HOSPITAL CENTER	33420	5945	42044
24T047	ST. LUKES ACUTE REHAB	03060	2240	20260
33T046	ST. LUKES HOSPITAL	16560	5600	35644
03T037	ST. LUKE'S HOSPITAL	26940	6200	38060
16T045	ST. LUKE'S HOSPITAL	36490	1360	16300
26T179	ST. LUKE'S REHAB UNIT AT ST. LUKE'S SOUTH SHORE	52580	7040	41180
36T090	ST. MARY MEDICAL CENTER	39140	8400	45780
52T138	ST. MARY MEDICAL CENTER INC	15440	7620	43100
39T258	ST. MARYS HOSPITAL AND MEDICAL CENTER	06380	6160	37964
15T034	ST. MARY'S REGIONAL MEDICAL CENTER	04570	2960	23844
06T023	ST. MARY'S REGIONAL MEDICAL CENTER	37230	2995	24300
04T041	ST. PETERS HOSPITAL	33000	04	04
37T026	ST. RITA'S MEDICAL CENTER	36010	2340	37
33T057	ST. ROSE DOMINICAN HOSPITAL	29010	0160	10580
36T066	ST. TAMMANY PARISH HOSPITAL	19510	4320	30620
29T012	ST. VINCENT INFIRMARY MEDICAL CENTER	04590	4120	29820
19T045	ST. VINCENT'S MEDICAL CENTER	07000	5560	35380
07T028	ST. FRANCIS HEALTH CENTER	17880	5483	14860
17T016	ST. JOSEPH HOSPITAL REHAB UNIT	15010	8440	45820
15T047	STAMFORD HOSPITAL	07070	2760	23060
073026	STANFORD HOSPITAL & CLINICS	05530	07	07
05T441	STANLY MEMORIAL HOSPITAL	34830	7400	41940
34T119	STARKE MEMORIAL HOSPITAL	15740	1520	34
15T102	STATEN ISLAND HOSPITAL	33610	15	15
33T160	STERLINGTON REHAB HOSPITAL	19360	5600	35644
193069	STILLWATER MEDICAL CENTER	37590	5200	33740
37T049	STRONG MEMORIAL HOSPITAL	33370	37	37
33T285	SUMMA HEALTH SYSTEM	36780	6840	40380
29T041	SUMMERLIN HOSPITAL MEDICAL CENTER	29010	4120	29820
36T020	SUMNER REGIONAL MEDICAL CENTER	44820	0080	10420
44T003	SUMTER REGIONAL HOSPITAL	11870	5360	34980
11T044	SUN COAST HOSPITAL	10510	11	11
10T015	SUN HEALTH ROBERT H BALLARD REHAB HOSPITAL	05460	8280	45300
053037	SUNNYVIEW HOSPITAL AND REHABILITATION CENTER	33650	6780	40140
333025	SUNRISE HOSPITAL & MEDICAL CEN	29010	0160	10580
29T003	SUNY DOWNSTATE MEDICAL CENTER	33331	4120	29820
33T350	SUTTER AUBURN FAITH HOSPITAL	05410	5600	35644
05T498	SWEDISH COVENANT HOSPITAL	14141	6920	40900
14T114	SWEDISH GENERAL REHABILITATION	06020	1600	16974
06T034	SWEDISH MEDICAL CENTER	50160	2080	19740
50T025	TAH INPATIENT REHAB UNIT	39260	7600	42644

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
39T122	TAKOMA ADVENTIST HOSPITAL	44290	39	39
44T050	TAMPA GENERAL REHABILATION CTR	10280	44	44
10T128	TARRANT COUNTY REHABILITATION HOSPITAL	45910	8280	45300
453042	TEMPLE UNIVERSITY HOSPITAL	39620	2800	23104
39T027	TERREBONNE GENERAL MEDICAL CENTER	19540	6160	37964
19T008	TEXOMA MEDICAL CENTER	45564	3350	26380
28T061	THE ACUTE REHAB UNIT AT REGIONAL WEST MEDICAL CENT	28780	28	28
20T018	THE AROOSTOOK MEDICAL CENTER	20010	20	20
36T163	THE CHRIST HOSPITAL REHAB UNIT	36310	1640	17140
09T001	THE GEORGE WASHINGTON UNIVERSITY ARU	09000	8840	47894
39T066	THE GOOD SAMARITAN HOSPITAL	39460	3240	30140
33T004	THE KINGSTON HOSPITAL REHABILITATION CENTER	33740	33	28740
25T099	THE LEFLORE REHABILITATION CENTER	25410	25	25
33T056	THE PARKSIDE ACUTE REHABILITATION CENTER	33331	5600	35644
33T049	THE PAUL ROSENTHAL REHABILITATION CENTER AT NDH	33230	2281	39100
39T044	THE READING HOSPITAL AND MEDICAL CENTER	39110	6680	39740
42T068	THE REGIONAL MEDICAL CENTER REHABCENTRE	42370	42	42
15T051	THE REHAB CENTER AT BLOOMINGTON HOSPITAL	15520	1020	14020
11T024	THE REHAB CENTER AT CANDLER	11220	7520	42340
44T059	THE REHAB CENTER AT COOKEVILLE RMC	44700	44	44
16T146	THE REHAB CENTER AT ST. LUKE'S	16960	7720	43580
11T043	THE REHAB CENTER AT ST. JOSEPHS	11220	7520	42340
15T008	THE REHABILITATION CENTER AT ST. CATHERINE HOSPITA	15440	2960	23844
10T012	THE REHABILITATION HOSPITAL	10350	2700	15980
20T039	THE REHABILITATION INSTITUTE AT MGMC	20050	20	20
42T067	THE REHABILITATION UNIT AT BEAUFORT MEMORIAL HOSPI	42060	42	42
36T211	THE TRINITY REHABILITATION CENTER	36420	8080	48260
39T042	THE WASHINGTON HOSPITAL ACUTE REHABILITATION UNIT	39750	6280	38300
52T045	THEDA CLARK MEDICAL CENTER	52690	0460	36780
19T004	THIBODAUX REGIONAL MEDICAL CENTER	19280	3350	26380
39T174	THOMAS JEFFERSON UNIVERSITY HOSPITAL	39620	6160	37964
343025	THOMS REHABILITATION HOSP	34100	0480	11700
23T015	THREE RIVERS REHABILITATION PAVILION	23740	23	23
11T095	TIFT REGIONAL MEDICAL CENTER	11900	11	11
45T080	TITUS REGIONAL MEDICAL CENTER	45531	45	45
45T324	TOMBALL REGIONAL HOSPITAL	45610	7640	43300
45T670	TOURO REHABILITATION CENTER	19350	3360	26420
193034	TRI-CITY MEDICAL CENTER	05470	5560	35380
05T128	TRI PARISH REHABILITATION HOSPITAL LLC	19050	7320	41740
193050	TRINITY MEDICAL CENTER	14890	19	19
14T280	TRINITY REHABCARE CENTER	35500	1960	19340
35T006	TULANE INPATIENT REHAB CENTER	19350	35	35
19T176	TULSA REGIONAL MEDICAL CENTER	37710	5560	35380
37T078	TWELVE OAKS MEDICAL CENTER	45610	8560	46140
45T378	TWIN RIVERS REGIONAL MEDICAL CENTER	26340	3360	26420
26T015	U W HOSPITAL & CLINIC	52120	26	26
52T098	UAB MEDICAL WEST REHABILITATION UNIT	01360	4720	31540
01T114	UC DAVIS MEDICAL CENTER	05440	1000	13820
05T599	UCLA MED CTR-RRU	05200	6920	40900
05T262	UHS HOSPITALS	33030	4480	31084
33T394	UNC HOSPITALS	34670	0960	13780
34T061	UNION HOSPITAL	15830	6640	20500
15T023	UNIONTOWN HOSPITAL	39330	8320	45460
39T041	UNITED MEDICAL CENTER ARU	53100	6280	38300
53T014	UNITED MEDICAL REHABILITATION HOSPITAL	19350	1580	16940
193079	UNITY HEALTH CENTER	37620	5560	35380
37T149	UNITY HEALTH SYSTEM	33370	5880	37
33T226	UNIV OF CA IRVINE MED CTR	05400	6840	40380
05T348	UNIV OF PITTSBURGH MED CTR-MUH	39010	5945	42044
39T164	UNIVERSITY COMMUNITY HOSPITAL	10280	6280	38300
10T173	UNIVERSITY HEALTH SYSTEM	45130	8280	45300
45T213	UNIVERSITY HOSPITAL	33520	7240	41700
33T241	UNIVERSITY MEDICAL CENTER	44940	8160	45060
44T193	UNIVERSITY MEDICAL CENTER	45770	5360	34980
45T686	UNIVERSITY OF COLORADO HOSPITAL	06150	4600	31180
06T024	UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO	14141	2080	19740
14T150	UNIVERSITY OF MICHIGAN HOSPITAL	23800	1600	16974

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
23T046	UNIVERSITY OF UTAH HOSPITAL	46170	0440	11460
46T009	UNIVERSITY OF WASHINGTON MED CTR	50160	7160	41620
50T008	UNIVERSITY REHABILITATION CENTER	25240	7600	42644
25T001	UPMC HORIZON	39530	3560	27140
39T178	UPMC LEE REGIONAL REHAB UNIT	39160	7610	49660
39T011	UPMC MCKEESPORT	39010	3680	27780
39T002	UPMC NORTHWEST	39730	6280	38300
39T091	UPMC PASSAVANT-REHABILITATION CENTER	39010	39	39
39T107	UPMC REHABILITATION HOSPITAL	39010	6280	38300
393042	UPMC SOUTHSIDE	39010	6280	38300
39T131	UPMC ST MARGARET	39010	6280	38300
39T102	UPPER VALLEY MEDICAL CENTER	36560	6280	38300
36T174	UTAH VALLEY REGIONAL MEDICAL CENTER-REHABILITATION	46240	2000	19380
46T001	UVA-HEALTHSOUTH REHABILITATION HOSPITAL	49191	6520	39340
493029	VALLEY BAPTIST HEALTH SYSTEM REHAB UNIT	45240	1540	16820
45T033	VALLEY HOSPITAL MEDICAL CENTER REHABILITAION UNIT	29010	1240	15180
29T021	VALLEY MEMORIAL HOSPITAL	05000	4120	29820
05T283	VALLEY PRESBYTERIAN HOSPITAL	05200	5775	36084
05T126	VALLEY VIEW HOSPITAL	06070	4480	31084
06T075	VALLEY VIEW REGIONAL HOSPITAL	37610	06	06
37T020	VAN MATRE HEALTHSOUTH REHABILITATION HOSPITAL	14991	37	37
143028	VANDERBILT STALLWORTH REHAB HOSPITAL	44180	6880	40420
443028	VCUHS	49791	5360	34980
49T032	VERMILION REHABILITATION HOSPITAL	19480	6760	40060
193047	VIA CHRISTI REHABILITATION CENTER	17860	3880	19
173028	VICTORIA WARM SPRINGS REHAB HOSPITAL	45948	9040	48620
453083	VICTORY MEMORIAL HOSPITAL	33331	8750	47020
33T242	VIRGINIA BAPTIST HOSPITAL	49551	5600	35644
49T021	VIRGINIA MASON MEDICAL CENTER	50160	4640	31340
50T005	VIRGINIA REGIONAL MEDICAL CENTER	24680	7600	42644
24T084	VISTA HEALTH ST. THERESE REHAB UNIT	14570	2240	20260
14T033	WACCAMAW REHABILITATION CENTER	42210	1600	29404
42T098	WADSWORTH RITTMAN HOSPITAL	36530	42	42
36T195	WAKEMED REHAB	34910	1680	17460
34T069	WALTER O. BOSWELL MEMORIAL HOSPITAL	03060	6640	39580
03T061	WALTON REHABILITATION HOSPITAL	11840	6200	38060
113026	WARMINSTER HOSPITAL	39140	0600	12260
39T286	WASHOE MEDICAL CENTER REHABILITATION HOSPITAL	29120	6160	37964
29T049	WASHOE VILLAGE REHAB	29150	29	16180
293030	WAUKESHA MEMORIAL HOSPITAL	52660	6720	39900
52T008	WAUSAU HOSPITAL	52360	5080	33340
52T030	WELDON CENTER FOR REHABILITATION	22070	8940	48140
22T066	WELLSTAR COBB HOSPITAL	11290	8003	44140
11T143	WELLSTAR KENNESTONE INPATIENT REHAB	11290	0520	12060
11T035	WENATCHEE VALLEY HOSPITAL REHABILITATION CENTER	50030	0520	12060
50T148	WESLACO REHABILITATION HOSPITAL	45650	50	48300
453091	WESLEY REHABILITATION HOSPITAL	17860	4880	32580
173027	WESLEY WOODS GERIATRIC HOSPITAL	11370	9040	48620
11T203	WEST ALLIS MEMORIAL HOSPITAL	52390	0520	12060
52T139	WEST FLORIDA REHAB INSTITUTE	10160	5080	33340
10T231	WEST HOUSTON MEDICAL CENTER	45610	6080	37860
45T644	WEST JEFFERSON MEDICAL CENTER	19250	3360	26420
19T039	WEST TENNESSEE REHABILITATION CENTER	44560	5560	35380
44T002	WEST VIRGINIA REHAB HOSP	51190	3580	27180
513029	WESTCHESTER MEDICAL CENTER	33800	1480	16620
33T234	WESTERN PENNSYLVANIA HOSPITAL	39010	5600	35644
39T090	WESTERN PLAINS MEDICAL COMPLEX	17280	6280	38300
17T175	WESTLAKE HOSPITAL	14141	17	17
14T240	WESTMORELAND REGIONAL HOSPITAL	39770	1600	16974
39T145	WESTVIEW HOSPITAL	15480	6280	38300
15T129	WHITAKER REHABILITATION CENTER	34330	3480	26900
34T014	WHITE COUNTY MEDICAL CENTER	04720	3120	49180
04T100	WHITE MEMORIAL MEDICAL CENTER	05200	04	04
05T103	WHITE RIVER MEDICAL CENTER	04310	4480	31084
04T119	WHITTIER REHABILITATION HOSPITAL	22040	04	04
223028	WHITTIER REHABILTATION HOSPITAL	22170	1123	21604
223033	WICHITA VALLEY REHABILITATION HOSPITAL	45960	1123	49340

TABLE 3.—INPATIENT REHABILITATION FACILITIES WITH CORRESPONDING STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION—Continued

Provider number	Provider name	SSA State and county code	FY 06 MSA code	FY 06 CBSA code
453088	WILLAMETTE VALLEY MEDICAL CENTER	38350	9080	48660
38T071	WILLIAM BEAUMONT HOSPITAL	23620	6440	38900
23T130	WILLIAM N. WISHARD MEMORIAL HOSPITAL	15480	2160	47644
39T045	WILLIAMSPORT HOSPITAL REHAB	39510	9140	48700
19T111	WILLIS-KNIGHTON MEDICAL CENTER	19080	7680	43340
45T469	WILSON N. JONES MEDICAL CENTER-MAIN CAMPUS	45564	7640	43300
45T393	WILSON N. JONES MEDICAL CENTER-NORTH CAMPUS	45564	7640	43300
49T005	WINCHESTER REHABILITATION CTR	49962	49	49020
15T014	WINONA MEMORIAL HOSPITAL	15480	3480	26900
10T052	WINTER HAVEN HOSPITAL	10520	3980	29460
33T239	WOMANS CHRISTIAN ASSOCIATION	33060	3610	33
33T396	WOODHULL MEDICAL CENTER	33331	5600	35644
45T484	WOODLAND HEIGHTS MEDICAL CENTER	45020	45	45
53T012	WYOMING MEDICAL CENTER	53120	1350	16220
50T012	YAKIMA REGIONAL	50380	9260	49420
07T022	YALE-NEW HAVEN HOSPITAL	07040	5483	35300
033034	YUMA REHABILITATION HOSPITAL	03130	9360	49740
45T766	ZALE LIPSHY UNIVERSITY HOSPITAL	45390	1920	19124

[FR Doc. 05–10264 Filed 5–19–05; 4:00 pm]

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