List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Chapter IV is amended as set forth below:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

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 A--General Provisions

2. Section §412.1 is revised to read as follows:

§**412.1 Scope of part.**

(a) Purpose. (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare

beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in §412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may

keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of §412.604.

(b) Summary of content. (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective

payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation

units effective with cost reporting periods beginning on or after January 1, 2002.

Subpart B--Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in §412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet

the conditions of §412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in §412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising introductory text of paragraph (h)(2).

§**412.22 Excluded hospitals and hospital units: General rules.**

(a) Criteria. Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in §412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in §412.23.

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section and §412.20(b), all excluded hospitals (and excluded hospital units, as described in §§412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of

hospital cost increases described in §413.40 of this subchapter.

* * * * *

(e) Hospitals within hospitals. Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in §412.1(a)(1):

* * * * *

(h) Satellite facilities. * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems specified in §412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text of the section.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in §412.1(a)(1):

* * * * *

(b) Rehabilitation hospitals. A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(2) and in Subpart P of this part:

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative

services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital’s regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in §412.1(a)(1) or is paid under the prospective payment system specified in §412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the

requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in accordance with the provisions in §412.130.

* * * * *

6. In §412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§**412.25 Excluded hospital units: Common requirements.**

(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) Satellite facilities. * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in §412.1(a)(1) for any period:

* * * * *

7. In §412.29, the introductory text is revised to read as follows:

§**412.29 Excluded rehabilitation units: Additional requirements.**

In order to be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H--Payments to Hospitals Under the Prospective Payment Systems

8. In §412.116, paragraph (a) is revised to read as follows:

§412.116 Method of payment.

(a) General rule. (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

* * * * *

9. In §412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§**412.130 Retroactive adjustments for incorrectly excluded hospitals and units.**

(a) Hospitals for which adjustment is made. * * *

(1) A hospital that was excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under §412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of §412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under §412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of §412.23(b)(2).

* * * * *

(b) Adjustment of payment. (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

Subparts N and O—-[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632, is added to read as follows:

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

Sec.

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

§412.600 Basis and scope of subpart.

(a) Basis. This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) Scope. This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

§412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

CMS stands for the Centers for Medicare & Medicaid Services.

Comorbidity means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Discharge. A Medicare patient in a inpatient rehabilitation facility is considered discharged when--

(1) The patient is formally released;

(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services; or

(3) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized patient assessment software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient

rehabilitation facility and ends on midnight of the third day.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Patient assessment instrument refers to a document that contains clinical, demographic, and other information on a patient.

Rural area means an area as defined in §412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in §412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in §412.62(f)(1)(ii).

§412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) General requirements. (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions

of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, we may, as appropriate--

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in §412.1(a)(1).

(b) Inpatient rehabilitation facilities subject to the prospective payment system. Subject to the special payment provisions of §412.22(c), an inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§412.23(b), 412.25, and 412.29 for

exclusion from the inpatient hospital prospective payment systems specified in §412.1(a)(1).

(c) Completion of patient assessment instrument. For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with §412.606.

(d) Limitation on charges to beneficiaries--(1) Prohibited charges. Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) Permitted charges. An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under §489.20(a) of this chapter.

(e) Furnishing of inpatient hospital services directly or under arrangement. (1) Subject to the provisions of §412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this subchapter. Inpatient hospital services do not include the following:

(i) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis).

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for

services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) Reporting and recordkeeping requirements. All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

§412.606 Patient assessments.

(a) Admission orders. At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) Patient assessment instrument. An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service inpatients who--

(1) Are admitted on or after January 1, 2002; or

(2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(c) Comprehensive assessments. (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in §412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include--

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family,

someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

§412.608 Patients' rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the patient assessment instrument, a clinician of the IRF must inform the Medicare Part A fee-for-service inpatient of the following patient rights:

(1) The right to be informed of the purpose of the collection of the patient assessment data;

(2) The right to have the patient assessment information collected be kept confidential and secure;

(3) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on his or her patient assessment.

(b) The inpatient rehabilitation facility must ensure that a clinician documents in the Medicare Part A fee-for-

service inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in §482.13 of this chapter.

§412.610 Assessment schedule.

(a) General. For each Medicare Part A fee-for-service inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in §412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) Starting the assessment schedule day count. The first day that the Medicare Part A fee-for-service inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) Assessment schedules and reference dates. The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-

service patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) Admission assessment.

(i) General rule. The admission assessment--

(A) Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization;

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed on the calendar day that follows the admission assessment reference day.

(ii) Exception to the general rule. We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) Discharge assessment.

(i) General rule. The discharge assessment--

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this

section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) Discharge assessment reference date. The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the IRF; or

(B) The patient stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services.

(iii) Exception to the general rule. We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) Encoding dates. The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) Accuracy of the patient assessment data. The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) Patient assessment instrument record retention. An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain.

§412.612 Coordination of the collection of patient assessment data.

(a) Responsibilities of the clinician. A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for--

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under §412.610(c).

(b) Penalty for falsification.

(1) Under Medicare, an individual who knowingly and willfully--

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§412.614 Transmission of patient assessment data.

(a) Data format. The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient––

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(b) How to transmit data. The inpatient rehabilitation facility must--

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) Transmission dates. The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in §412.610(d).

(d) Late transmission penalty. (1) We assess a penalty when an inpatient rehabilitation facility does not transmit the required data from the patient assessment instrument to the our patient data system in accordance

with the transmission timeframe in paragraph (c) of this section.

(2) If the actual patient assessment data transmission date is later than 10 calendar days from the transmission date specified in paragraph (c) of this section, the patient assessment data is considered late and the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

§412.616 Release of information collected using the patient assessment instrument.

(a) General. An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in §482.24(b)(3) of this chapter.

(b) Release to the inpatient rehabilitation facility's agent. An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§**412.618 Assessment process for interrupted stays.**

For purposes of the patient assessment process, if a Medicare Part A fee-for-service patient has an interrupted stay, as defined under §412.602, the following applies:

(a) Assessment requirements. (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) Recording and encoding of data. The clinician must record the interruption of the stay on the patient assessment instrument.

(c) Revised assessment schedule. (1) If the interruption in the stay occurs before the admission assessment, the assessment reference date, completion dates, encoding dates, and data transmission dates for the admission and discharge assessments are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

(2) If the interruption in the stay occurs after the admission assessment and before the discharge assessment,

the completion date, encoding date, and data transmission date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

§412.620 Patient classification system.

(a) Classification methodology.

(1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under §412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under §412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) Weighting factors.

(1) General. An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) Short-stay outliers. We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in §412.602) within a number of days from admission as specified by us.

(3) Patients who expire. We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) Comorbidities. We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in §412.602, that is relevant to resource use in the classification system.

(c) Revision of case-mix group classifications and weighting factors. We may periodically adjust the case-mix groups and weighting factors to reflect changes in--

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§412.622 Basis of payment.

(a) Method of payment.

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in §412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in §412.626.

(b) Payment in full. (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in §413.80 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§412.624 Methodology for calculating the Federal prospective payment rates.

(a) Data used. To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use--

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in §412.606 and other data that account for the relative resource utilization of different patient types.

(b) Determining the average costs per discharge for fiscal year 2001. We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) Determining the Federal prospective payment rates. (1) General. The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) Update the cost per discharge. We apply the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, we estimate the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) Computation of the budget neutral conversion factor. The budget neutral conversion factor is computed as follows:

(i) For fiscal year 2002. Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, we compute a budget neutral conversion factor for fiscal year 2002, as specified by us, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) For fiscal years after 2002. The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of

this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) Determining the Federal prospective payment rate for each case-mix group. The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in §412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) Adjustments to the budget neutral conversion factor. The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) Outlier payments. We determine a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) Budget neutrality. We adjust the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under §412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities

under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) Coding and classification changes. We adjust the budget neutral conversion factor for a given year if we determine that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) Calculation of the adjusted Federal prospective payment. For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) Adjustment for area wage levels. The labor portion of a facility's Federal prospective payment is

adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in §412.602.

(2) Adjustments for low-income patients. We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) Adjustments for rural areas. We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in §412.602.

(4) Adjustment for high-cost outliers. We provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by us. 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.

(5) 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.

(f) Special payment provision for patients that are transferred.

(1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who--

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in §412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount.

(g) Special payment provision for interrupted stays. When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in §412.602 and as indicated on the patient assessment instrument in accordance with §412.618(b), we will make payments in the following manner:

(1) Interruption of one day or less. Payment for a patient stay with an interruption of one day or less will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1). Payment for an interruption of one day or less will only be made to the inpatient rehabilitation facility.

(2) Interruption of more than one day. Payment for a patient stay with an interruption of more than one day but less than 3 consecutive days, as defined in §412.602, will be--

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in §412.1(a)(1) made to the acute care hospital.

§412.626 Transition period.

(a) Duration of transition period and proportion of the blended transition rate. (1) Except for a facility that makes an election under paragraph (b) of this section,

for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under §412.624(e) or §412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33 1/3 percent of the facility-specific payment and 66 2/3 percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) Calculation of the facility-specific payment. The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) Election not to be paid under the transition period methodology. An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) General requirement. An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) Notification requirement to make election. The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins

will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received or not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

§412.628 Publication of the Federal prospective payment rates.

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard

to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) General rule. Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) Periodic interim payments.

(1) Criteria for receiving periodic interim payments.

(i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in §412.116.

(iv) As provided in §413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) Frequency of payment. For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if

an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) Termination of PIP. (i) Request by the inpatient rehabilitation facility. Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) Removal by the intermediary. An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of §413.64(h) of this chapter.

(c) Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system. For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each

payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) Outlier payments. Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) Accelerated payments. (1) General rule. Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's

preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) Approval of payment. An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) Recovery of payment. Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

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

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A -- Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§**413.1 Introduction.**

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of §413.40.

* * * * *

(iv) For cost reporting periods beginning before January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of §413.40.

(v) For cost reporting periods beginning on or after January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of §412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C-- Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding a new paragraph (a)(2)(iii).

§413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) Introduction. * * *

(2) Applicability. (i) This section is not applicable to--

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for

inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after January 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to--

(A) Hospitals excluded from the prospective payment systems described in §412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in §412.1(a)(1) of this chapter and in accordance with §§412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before January 1, 2002, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in §412.1(a)(1) of this subchapter.

* * * * *

Subpart E-- Payments to Providers

4. In §413.64, paragraph (h)(2)(i) is revised to read as follows:

§413.64 Payment to providers: Specific rules.

* * * * *

(h) Periodic interim payment method of reimbursement--

* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in §412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance)

Dated: _____

_____

Thomas A. Scully,
Administrator,
Centers for Medicare & Medicaid Services

Dated: _____

_____

Tommy G. Thompson,
Secretary.

BILLING CODE 4120-01

Editorial Note: The following Addendum and Appendix A through Appendix D to the preamble will not appear in the Code of Federal Regulations.

Addendum--Tables

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

Table 1 – Relative Weights for Case-Mix Groups (CMGs)

Table 2 – Federal Prospective Payments for Case-Mix Groups

Table 3A – Wage Index for Urban Areas

Table 3B – Wage Index for Rural Areas

Table 1.--Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M=69-84 and C=23-35	0.4778	0.4279	0.4078	0.3859	10	9	6	8
0102	Stroke M=59-68 and C=23-35	0.6506	0.5827	0.5553	0.5255	11	12	10	10
0103	Stroke M=59-84 and C=5-22	0.8296	0.7430	0.7080	0.6700	14	12	12	12
0104	Stroke M=53-58	0.9007	0.8067	0.7687	0.7275	17	13	12	13
0105	Stroke M=47-52	1.1339	1.0155	0.9677	0.9158	16	17	15	15
0106	Stroke M=42-46	1.3951	1.2494	1.1905	1.1267	18	18	18	18
0107	Stroke M=39-41	1.6159	1.4472	1.3790	1.3050	17	20	21	21
0108	Stroke M=34-38 and A>=83	1.7477	1.5653	1.4915	1.4115	25	27	22	23
0109	Stroke M=34-38 and A<=82	1.8901	1.6928	1.6130	1.5265	24	24	22	24
0110	Stroke M=12-33 and A>=89	2.0275	1.8159	1.7303	1.6375	29	25	27	26
0111	Stroke M=27-33 and A=82-88	2.0889	1.8709	1.7827	1.6871	29	26	24	27
0112	Stroke M=12-26 and A=82-88	2.4782	2.2195	2.1149	2.0015	40	33	30	31
0113	Stroke M=27-33 and A<=81	2.2375	2.0040	1.9095	1.8071	30	27	27	28
0114	Stroke M=12-26 and A<=81	2.7302	2.4452	2.3300	2.2050	37	34	32	33
0201	Traumatic brain injury M=52-84 and C=24-35	0.7689	0.7276	0.6724	0.6170	13	14	14	11
0202	Traumatic brain injury M=40-51 and C=24-35	1.1181	1.0581	0.9778	0.8973	18	16	17	16
0203	Traumatic brain injury M=40-84 and C=5-23	1.3077	1.2375	1.1436	1.0495	19	20	19	18
0204	Traumatic brain injury M=30-39	1.6534	1.5646	1.4459	1.3269	24	23	22	22
0205	Traumatic brain injury M=12-29	2.5100	2.3752	2.1949	2.0143	44	36	35	31
0301	Non-traumatic brain injury M=51-84	0.9655	0.8239	0.7895	0.7195	14	14	12	13
0302	Non-traumatic brain injury M=41-50	1.3678	1.1672	1.1184	1.0194	19	17	17	16

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0303	Non-traumatic brain injury M=25-40	1.8752	1.6002	1.5334	1.3976	23	23	22	22
0304	Non-traumatic brain injury M=12-24	2.7911	2.3817	2.2824	2.0801	44	32	34	31
0401	Traumatic spinal cord injury M=50-84	0.9282	0.8716	0.8222	0.6908	15	15	16	14
0402	Traumatic spinal cord injury M=36-49	1.4211	1.3344	1.2588	1.0576	21	18	22	19
0403	Traumatic spinal cord injury M=19-35	2.3485	2.2052	2.0802	1.7478	32	32	31	30
0404	Traumatic spinal cord injury M=12-18	3.5227	3.3078	3.1203	2.6216	46	43	62	40
0501	Non-traumatic spinal cord injury M=51-84 and C=30-35	0.7590	0.6975	0.6230	0.5363	12	13	10	10
0502	Non-traumatic spinal cord injury M=51-84 and C=5-29	0.9458	0.8691	0.7763	0.6683	15	17	10	12
0503	Non-traumatic spinal cord injury M=41-50	1.1613	1.0672	0.9533	0.8206	17	17	15	14
0504	Non-traumatic spinal cord injury M=34-40	1.6759	1.5400	1.3757	1.1842	23	21	21	19
0505	Non-traumatic spinal cord injury M=12-33	2.5314	2.3261	2.0778	1.7887	31	31	29	28
0601	Neurological M=56-84	0.8794	0.6750	0.6609	0.5949	14	13	12	12
0602	Neurological M=47-55	1.1979	0.9195	0.9003	0.8105	15	15	14	15
0603	Neurological M=36-46	1.5368	1.1796	1.1550	1.0397	21	18	18	18
0604	Neurological M=12-35	2.0045	1.5386	1.5065	1.3561	31	24	25	23
0701	Fracture of lower extremity M=52-84	0.7015	0.7006	0.6710	0.5960	13	13	12	11
0702	Fracture of lower extremity M=46-51	0.9264	0.9251	0.8861	0.7870	15	15	16	14
0703	Fracture of lower extremity M=42-45	1.0977	1.0962	1.0500	0.9326	18	17	17	16
0704	Fracture of lower extremity M=38-41	1.2488	1.2471	1.1945	1.0609	14	20	19	18
0705	Fracture of lower extremity M=12-37	1.4760	1.4740	1.4119	1.2540	20	22	22	21
0801	Replacement of lower extremity joint M=58-84	0.4909	0.4696	0.4518	0.3890	9	9	8	8

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0802	Replacement of lower extremity joint M=55-57	0.5667	0.5421	0.5216	0.4490	10	10	9	9
0803	Replacement of lower extremity joint M=47-54	0.6956	0.6654	0.6402	0.5511	9	11	11	10
0804	Replacement of lower extremity joint M=12-46 and C=32-35	0.9284	0.8881	0.8545	0.7356	15	14	14	12
0805	Replacement of lower extremity joint M=40-46 and C=5-31	1.0027	0.9593	0.9229	0.7945	16	16	14	14
0806	Replacement of lower extremity joint M=12-39 and C=5-31	1.3681	1.3088	1.2592	1.0840	21	20	19	18
0901	Other orthopedic M=54-84	0.6988	0.6390	0.6025	0.5213	12	11	11	11
0902	Other orthopedic M=47-53	0.9496	0.8684	0.8187	0.7084	15	15	14	13
0903	Other orthopedic M=38-46	1.1987	1.0961	1.0334	0.8942	18	18	17	16
0904	Other orthopedic M=12-37	1.6272	1.4880	1.4029	1.2138	23	23	23	21
1001	Amputation, lower extremity M=61-84	0.7821	0.7821	0.7153	0.6523	13	13	12	13
1002	Amputation, lower extremity M=52-60	0.9998	0.9998	0.9144	0.8339	15	15	14	15
1003	Amputation, lower extremity M=46-51	1.2229	1.2229	1.1185	1.0200	18	17	17	18
1004	Amputation, lower extremity M=39-45	1.4264	1.4264	1.3046	1.1897	20	20	19	19
1005	Amputation, lower extremity M=12-38	1.7588	1.7588	1.6086	1.4670	21	25	23	23
1101	Amputation, non-lower extremity M=52-84	1.2621	0.7683	0.7149	0.6631	18	11	13	12
1102	Amputation, non-lower extremity M=38-51	1.9534	1.1892	1.1064	1.0263	25	18	17	18

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1103	Amputation, non-lower extremity M=12-37	2.6543	1.6159	1.5034	1.3945	33	23	22	25
1201	Osteoarthritis M=55-84 and C=34-35	0.7219	0.5429	0.5103	0.4596	13	10	11	9
1202	Osteoarthritis M=55-84 and C=5-33	0.9284	0.6983	0.6563	0.5911	16	11	13	13
1203	Osteoarthritis M=48-54	1.0771	0.8101	0.7614	0.6858	18	15	14	13
1204	Osteoarthritis M=39-47	1.3950	1.0492	0.9861	0.8882	22	19	16	17
1205	Osteoarthritis M=12-38	1.7874	1.3443	1.2634	1.1380	27	21	21	20
1301	Rheumatoid, other arthritis M=54-84	0.7719	0.6522	0.6434	0.5566	13	14	13	11
1302	Rheumatoid, other arthritis M=47-53	0.9882	0.8349	0.8237	0.7126	16	14	14	14
1303	Rheumatoid, other arthritis M=36-46	1.3132	1.1095	1.0945	0.9469	20	18	16	17
1304	Rheumatoid, other arthritis M=12-35	1.8662	1.5768	1.5555	1.3457	25	25	29	22
1401	Cardiac M=56-84	0.7190	0.6433	0.5722	0.5156	15	12	11	11
1402	Cardiac M=48-55	0.9902	0.8858	0.7880	0.7101	13	15	13	13
1403	Cardiac M=38-47	1.2975	1.1608	1.0325	0.9305	21	19	16	16
1404	Cardiac M=12-37	1.8013	1.6115	1.4335	1.2918	30	24	21	20
1501	Pulmonary M=61-84	0.8032	0.7633	0.6926	0.6615	15	13	13	13
1502	Pulmonary M=48-60	1.0268	0.9758	0.8855	0.8457	17	17	14	15
1503	Pulmonary M=36-47	1.3242	1.2584	1.1419	1.0906	21	20	18	18
1504	Pulmonary M=12-35	2.0598	1.9575	1.7763	1.6965	30	28	30	26
1601	Pain syndrome M=45-84	0.8707	0.8327	0.7886	0.6603	15	14	13	13
1602	Pain syndrome M=12-44	1.3320	1.2739	1.2066	1.0103	21	20	20	18
1701	Major multiple trauma without brain or spinal cord injury M=46-84	0.9996	0.9022	0.8138	0.7205	16	14	11	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1702	Major multiple trauma without brain or spinal cord injury M=33-45	1.4755	1.3317	1.2011	1.0634	21	21	20	18
1703	Major multiple trauma without brain or spinal cord injury M=12-32	2.1370	1.9288	1.7396	1.5402	33	28	27	24
1801	Major multiple trauma with brain or spinal cord injury M=45-84 and C=33-35	0.7445	0.7445	0.6862	0.6282	12	12	12	10
1802	Major multiple trauma with brain or spinal cord injury M=45-84 and C=5-32	1.0674	1.0674	0.9838	0.9007	16	16	16	16
1803	Major multiple trauma with brain or spinal cord injury M=26-44	1.6350	1.6350	1.5069	1.3797	22	25	20	22
1804	Major multiple trauma with brain or spinal cord injury M=12-25	2.9140	2.9140	2.6858	2.4589	41	29	40	40
1901	Guillian Barre M=47-84	1.1585	1.0002	0.9781	0.8876	15	15	16	15
1902	Guillian Barre M=31-46	2.1542	1.8598	1.8188	1.6505	27	27	27	24
1903	Guillian Barre M=12-30	3.1339	2.7056	2.6459	2.4011	41	35	30	40
2001	Miscellaneous M=54-84	0.8371	0.7195	0.6705	0.6029	12	13	11	12
2002	Miscellaneous M=45-53	1.1056	0.9502	0.8855	0.7962	15	15	14	14
2003	Miscellaneous M=33-44	1.4639	1.2581	1.1725	1.0543	20	18	18	18
2004	Miscellaneous M=12-32 and A>=82	1.7472	1.5017	1.3994	1.2583	30	22	21	22
2005	Miscellaneous M=12-32 and A<=81	2.0799	1.7876	1.6659	1.4979	33	25	24	24
2101	Burns M=46-84	1.0357	0.9425	0.8387	0.8387	18	18	15	16
2102	Burns M=12-45	2.2508	2.0482	1.8226	1.8226	31	26	26	29

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
5001	Short-stay cases, length of stay is 3 days or fewer	.	.	.	0.1651	.	.	.	3
5101	Expired, orthopedic, length of stay is 13 days or fewer	.	.	.	0.4279	.	.	.	8
5102	Expired, orthopedic, length of stay is 14 days or more	.	.	.	1.2390	.	.	.	23
5103	Expired, not orthopedic, length of stay is 15 days or fewer	.	.	.	0.5436	.	.	.	9
5104	Expired, not orthopedic, length of stay is 16 days or more	.	.	.	1.7100	.	.	.	28

TABLE 2.--Federal Prospective Payments for Case-Mix Groups (CMGs)

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0101	$ 5,656.20	$ 5,065.48	$ 4,827.54	$ 4,568.28
0102	7,701.80	6,898.00	6,573.64	6,220.87
0103	9,820.80	8,795.63	8,381.30	7,931.46
0104	10,662.49	9,549.71	9,099.87	8,612.15
0105	13,423.11	12,021.49	11,455.63	10,841.24
0106	16,515.19	14,790.40	14,093.14	13,337.87
0107	19,129.02	17,131.95	16,324.60	15,448.59
0108	20,689.27	18,530.02	17,656.38	16,709.34
0109	22,375.00	20,039.37	19,094.69	18,070.71
0110	24,001.55	21,496.62	20,483.29	19,384.73
0111	24,728.40	22,147.71	21,103.60	19,971.89
0112	29,336.93	26,274.44	25,036.19	23,693.76
0113	26,487.53	23,723.35	22,604.66	21,392.45
0114	32,320.11	28,946.28	27,582.54	26,102.79
0201	9,102.24	8,613.33	7,959.87	7,304.05
0202	13,236.07	12,525.79	11,575.20	10,622.24
0203	15,480.55	14,649.53	13,537.94	12,423.98
0204	19,572.95	18,521.73	17,116.56	15,707.84
0205	29,713.38	28,117.62	25,983.23	23,845.28
0301	11,429.59	9,753.33	9,346.10	8,517.44
0302	16,192.02	13,817.31	13,239.62	12,067.66
0303	22,198.62	18,943.17	18,152.39	16,544.79
0304	33,041.04	28,194.56	27,019.05	24,624.22
0401	10,988.03	10,318.00	9,733.20	8,177.69
0402	16,822.98	15,796.63	14,901.67	12,519.87
0403	27,801.54	26,105.16	24,625.41	20,690.46
0404	41,701.72	39,157.74	36,938.11	31,034.50
0501	8,985.04	8,257.01	7,375.07	6,348.72
0502	11,196.38	10,288.41	9,189.84	7,911.34
0503	13,747.47	12,633.51	11,285.17	9,714.26
0504	19,839.30	18,230.52	16,285.54	14,018.56
0505	29,966.71	27,536.37	24,597.00	21,174.63
0601	10,410.34	7,990.65	7,823.73	7,042.43
0602	14,180.74	10,885.04	10,657.75	9,594.70
0603	18,192.64	13,964.10	13,672.89	12,307.97

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0604	23,729.27	18,213.95	17,833.95	16,053.51
0701	8,304.36	8,293.70	7,943.30	7,055.45
0702	10,966.72	10,951.33	10,489.65	9,316.51
0703	12,994.57	12,976.82	12,429.90	11,040.12
0704	14,783.29	14,763.17	14,140.49	12,558.93
0705	17,472.89	17,449.21	16,714.07	14,844.85
0801	5,811.27	5,559.12	5,348.41	4,604.98
0802	6,708.59	6,417.38	6,174.70	5,315.26
0803	8,234.51	7,877.01	7,578.69	6,523.92
0804	10,990.40	10,513.33	10,115.57	8,708.03
0805	11,869.96	11,356.19	10,925.29	9,405.29
0806	16,195.57	15,493.57	14,906.41	12,832.39
0901	8,272.39	7,564.48	7,132.40	6,171.15
0902	11,241.36	10,280.12	9,691.77	8,386.04
0903	14,190.21	12,975.63	12,233.39	10,585.54
0904	19,262.79	17,614.94	16,607.53	14,368.96
1001	9,258.50	9,258.50	8,467.72	7,721.93
1002	11,835.63	11,835.63	10,824.67	9,871.71
1003	14,476.69	14,476.69	13,240.80	12,074.76
1004	16,885.72	16,885.72	15,443.85	14,083.67
1005	20,820.67	20,820.67	19,042.61	17,366.35
1101	14,940.74	9,095.14	8,462.99	7,849.78
1102	23,124.35	14,077.75	13,097.56	12,149.34
1103	31,421.60	19,129.02	17,797.25	16,508.09
1201	8,545.85	6,426.85	6,040.93	5,440.74
1202	10,990.40	8,266.48	7,769.28	6,997.44
1203	12,750.71	9,589.96	9,013.45	8,118.50
1204	16,514.01	12,420.43	11,673.45	10,514.51
1205	21,159.24	15,913.82	14,956.13	13,471.64
1301	9,137.75	7,720.74	7,616.57	6,589.03
1302	11,698.31	9,883.55	9,750.96	8,435.76
1303	15,545.66	13,134.26	12,956.69	11,209.40
1304	22,092.08	18,666.16	18,414.01	15,930.40
1401	8,511.52	7,615.39	6,773.70	6,103.67
1402	11,721.99	10,486.10	9,328.34	8,406.16
1403	15,359.81	13,741.55	12,222.74	11,015.26
1404	21,323.79	19,076.94	16,969.77	15,292.33
1501	9,508.28	9,035.95	8,199.00	7,830.84
1502	12,155.26	11,551.52	10,482.55	10,011.40

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
1503	15,675.88	14,896.94	13,517.81	12,910.52
1504	24,383.91	23,172.89	21,027.84	20,083.17
1601	10,307.35	9,857.50	9,335.45	7,816.63
1602	15,768.22	15,080.43	14,283.73	11,959.93
1701	11,833.26	10,680.24	9,633.76	8,529.28
1702	17,466.97	15,764.66	14,218.62	12,588.53
1703	25,297.81	22,833.13	20,593.38	18,232.89
1801	8,813.39	8,813.39	8,123.24	7,436.63
1802	12,635.88	12,635.88	11,646.22	10,662.49
1803	19,355.13	19,355.13	17,838.68	16,332.89
1804	34,495.93	34,495.93	31,794.50	29,108.46
1901	13,714.32	11,840.37	11,578.75	10,507.41
1902	25,501.42	22,016.31	21,530.95	19,538.62
1903	37,099.11	32,028.89	31,322.16	28,424.22
2001	9,909.59	8,517.44	7,937.38	7,137.13
2002	13,088.09	11,248.47	10,482.55	9,425.42
2003	17,329.65	14,893.39	13,880.06	12,480.80
2004	20,683.35	17,777.12	16,566.10	14,895.76
2005	24,621.86	21,161.61	19,720.92	17,732.14
2101	12,260.62	11,157.32	9,928.53	9,928.53
2102	26,644.97	24,246.59	21,575.94	21,575.94
5001				1,954.45
5101				5,065.48
5102				14,667.28
5103				6,435.14
5104				20,242.98

Table 3A.--Wage Index for Urban Areas

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0040	Abilene, TX Taylor, TX	0.8240
0060	Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4391
0080	Akron, OH Portage, OH Summit, OH	0.9541
0120	Albany, GA Dougherty, GA Lee, GA	0.9893
0160	Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8480
0200	Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.9146
0220	Alexandria, LA Rapides, LA	0.8121
0240	Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9839
0280	Altoona, PA Blair, PA	0.9317
0320	Amarillo, TX Potter, TX Randall, TX	0.8673
0380	Anchorage, AK Anchorage, AK	1.2775
0440	Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.1093

0450	Anniston,AL Calhoun, AL	0.8284
0460	Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.9052
0470	Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.4525
0480	Asheville, NC Buncombe, NC Madison, NC	0.9479
0500	Athens, GA Clarke, GA Madison, GA Oconee, GA	0.9739
0520	Atlanta, GA 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	1.0097
0560	Atlantic City-Cape May, NJ Atlantic City, NJ Cape May, NJ	1.1167
0580	Auburn-Opelika, AL Lee, AL	0.8079

0600	Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9127
0640	Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9540
0680	Bakersfield, CA Kern, CA	0.9684
0720	Baltimore, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Annes, MD	0.9223
0733	Bangor, ME Penobscot, ME	0.9550
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.3801
0760	Baton Rouge, LA Ascension, LA East Baton Rouge Livingston, LA West Baton Rouge, LA	0.8796
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8734
0860	Bellingham, WA Whatcom, WA	1.1439
0870	Benton Harbor, MI Berrien, MI	0.8671
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.1818
0880	Billings, MT Yellowstone, MT	0.9604

0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.8236
0960	Binghamton, NY Broome, NY Tioga, NY	0.8600
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.8360
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7625
1020	Bloomington, IN Monroe, IN	0.8733
1040	Bloomington-Normal, IL McLean, IL	0.9095
1080	Boise City, ID Ada, ID Canyon, ID	0.9006
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1086
1125	Boulder-Longmont, CO Boulder, CO	0.9731
1145	Brazoria, TX Brazoria, TX	0.8658
1150	Bremerton, WA Kitsap, WA	1.0975
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	0.8714
1260	Bryan-College Station, TX Brazos, TX	0.8237

1280	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9455
1303	Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0840
1310	Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.4548
1320	Canton-Massillon, OH Carroll, OH Stark, OH	0.8480
1350	Casper, WY Natrona, WY	0.8724
1360	Cedar Rapids, IA Linn, IA	0.8716
1400	Champaign-Urbana, IL Champaign, IL	0.9189
1440	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.9029
1480	Charleston, WV Kanawha, WV Putnam, WV	0.9235
1520	Charlotte-Gastonia-Rock Hill, NC-SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC York, SC	0.9321
1540	Charlottesville, VA Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	1.0581

1560	Chattanooga, TN-GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	0.9790
1580	Cheyenne, WY Laramie, WY	0.8308
1600	Chicago, IL Cook, IL De Kalb, IL Du Page, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	1.1092
1620	Chico-Paradise, CA Butte, CA	0.9918
1640	Cincinnati, OH-KY-IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH	0.9349
1660	Clarksville-Hopkinsville, TN-KY Christian, KY Montgomery, TN	0.8173
1680	Cleveland-Lorain-Elyria, OH Ashtabula, OH Geauga, OH Cuyahoga, OH Lake, OH Lorain, OH Medina, OH	0.9528
1720	Colorado Springs, CO El Paso, CO	0.9698

1740	Columbia MO Boone, MO	0.8920
1760	Columbia, SC Lexington, SC Richland, SC	0.9557
1800	Columbus, GA-AL Russell,AL Chattanoochee, GA Harris, GA Muscogee, GA	0.8531
1840	Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.9573
1880	Corpus Christi, TX Nueces, TX San Patricio, TX	0.8746
1890	Corvallis, OR Benton, OR	1.1326
1900	Cumberland, MD-WV Allegany MD Mineral WV	0.8369
1920	Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	0.9792
1950	Danville, VA Danville City, VA Pittsylvania, VA	0.8589
1960	Davenport-Moline-Rock Island, IA-IL Scott, IA Henry, IL Rock Island, IL	0.8897

2000	Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9384
2020	Daytona Beach, FL Flagler, FL Volusia, FL	0.9165
2030	Decatur, AL Lawrence, AL Morgan, AL	0.8534
2040	Decatur, IL Macon, IL	0.8095
2080	Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.0120
2120	Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.9073
2160	Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0364
2180	Dothan, AL Dale, AL Houston, AL	0.7943
2190	Dover, DE Kent, DE	1.0078
2200	Dubuque, IA Dubuque, IA	0.8746
2240	Duluth-Superior, MN-WI St. Louis, MN Douglas, WI	1.0032
2281	Dutchess County, NY Dutchess, NY	1.0187
2290	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.8761

2320	El Paso, TX El Paso, TX	0.9332
2330	Elkhart-Goshen, IN Elkhart, IN	0.9145
2335	Elmira, NY Chemung, NY	0.8546
2340	Enid, OK Garfield, OK	0.8610
2360	Erie, PA Erie, PA	0.8892
2400	Eugene-Springfield, OR Lane, OR	1.0960
2440	Evansville-Henderson, IN-KY Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8137
2520	Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.8750
2560	Fayetteville, NC Cumberland, NC	0.8655
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.7910
2620	Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0681
2640	Flint, MI Genesee, MI	1.1153
2650	Florence, AL Colbert, AL Lauderdale, AL	0.7616
2655	Florence, SC Florence, SC	0.8737
2670	Fort Collins-Loveland, CO Larimer, CO	1.0620
2680	Ft. Lauderdale, FL Broward, FL	1.0118
2700	Fort Myers-Cape Coral, FL Lee, FL	0.9247
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	0.9538

2720	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8052
2750	Fort Walton Beach, FL Okaloosa, FL	0.9607
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.8647
2800	Fort Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9392
2840	Fresno, CA Fresno, CA Madera, CA	1.0057
2880	Gadsden, AL Etowah, AL	0.8423
2900	Gainesville, FL Alachua, FL	0.9741
2920	Galveston-Texas City, TX Galveston, TX	0.9796
2960	Gary, IN Lake, IN Porter, IN	0.9451
2975	Glens Falls, NY Warren, NY Washington, NY	0.8361
2980	Goldsboro, NC Wayne, NC	0.8423
2985	Grand Forks, ND-MN Polk, MN Grand Forks, ND	0.8774
2995	Grand Junction, CO Mesa, CO	0.8947
3000	Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI Muskegon, MI Ottawa, MI	1.0070

3040	Great Falls, MT Cascade, MT	0.9065
3060	Greeley, CO Weld, CO	0.9664
3080	Green Bay, WI Brown, WI	0.9207
3120	Greensboro-Winston-Salem-High Point, NC Alamance, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC	0.9068
3150	Greenville, NC Pitt, NC	0.9402
3160	Greenville-Spartanburg-Anderson, SC Anderson, SC Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC	0.8894
3180	Hagerstown, MD Washington, MD	0.9409
3200	Hamilton-Middletown, OH Butler, OH	0.9061
3240	Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9338
3283	Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1236
3285	Hattiesburg, MS Forrest, MS Lamar, MS	0.7490
3290	Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9008

3320	Honolulu, HI Honolulu, HI	1.1865
3350	Houma, LA Lafourche, LA Terrebonne, LA	0.8100
3360	Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	0.9663
3400	Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9876
3440	Huntsville, AL Limestone, AL Madison, AL	0.8932
3480	Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN	0.9747
3500	Iowa City, IA Johnson, IA	0.9537
3520	Jackson, MI Jackson, MI	0.9134
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8749
3580	Jackson, TN Chester, TN Madison, TN	0.8796

3600	Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.9186
3605	Jacksonville, NC Onslow, NC	0.7777
3610	Jamestown, NY Chautaqua, NY	0.7818
3620	Janesville-Beloit, WI Rock, WI	0.9587
3640	Jersey City, NJ Hudson, NJ	1.1440
3660	Johnson City-Kingsport-Bristol, TN-VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8272
3680	Johnstown, PA Cambria, PA Somerset, PA	0.8767
3700	Jonesboro, AR Craighead, AR	0.7831
3710	Joplin, MO Jasper, MO Newton, MO	0.8148
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	1.0440
3740	Kankakee, IL Kankakee, IL	0.9902

3760	Kansas City, KS-MO Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	0.9458
3800	Kenosha, WI Kenosha, WI	0.9611
3810	Killeen-Temple, TX Bell, TX Coryell, TX	1.0164
3840	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.8221
3850	Kokomo, IN Howard, IN Tipton, IN	0.9518
3870	La Crosse, WI-MN Houston, MN La Crosse, WI	0.9197
3880	Lafayette, LA Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	0.8390
3920	Lafayette, IN Clinton, IN Tippecanoe, IN	0.8834
3960	Lake Charles, LA Calcasieu, LA	0.7399
3980	Lakeland-Winter Haven, FL Polk, FL	0.9239
4000	Lancaster, PA Lancaster, PA	0.9247

4040	Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	0.9880
4080	Laredo, TX Webb, TX	0.8168
4100	Las Cruces, NM Dona Ana, NM	0.8639
4120	Las Vegas, NV-AZ Mohave, AZ Clark, NV Nye, NV	1.0796
4150	Lawrence, KS Douglas, KS	0.8190
4200	Lawton, OK Comanche, OK	0.8996
4243	Lewiston-Auburn, ME Androscoggin, ME	0.9003
4280	Lexington, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY	0.8774
4320	Lima, OH Allen, OH Auglaize, OH	0.9320
4360	Lincoln, NE Lancaster, NE	0.9619
4400	Little Rock-North Little, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	0.8908
4420	Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8922
4480	Los Angeles-Long Beach, CA Los Angeles, CA	1.1984

4520	Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9261
4600	Lubbock, TX Lubbock, TX	0.8848
4640	Lynchburg, VA Amherst, VA Bedford City, VA Bedford, VA Campbell, VA Lynchburg City, VA	0.8851
4680	Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.8848
4720	Madison, WI Dane, WI	1.0316
4800	Mansfield, OH Crawford, OH Richland, OH	0.8690
4840	Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4577
4880	McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8566
4890	Medford-Ashland, OR Jackson, OR	1.0344
4900	Melbourne-Titusville-Palm Bay, FL Brevard, FL	0.9688

4920	Memphis, TN-AR-MS Crittenden, AR De Soto, MS Fayette, TN Shelby, TN Tipton, TN	0.8688
4940	Merced, CA Merced, CA	0.9559
5000	Miami, FL Dade, FL	1.0110
5015	Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.0987
5080	Milwaukee-Waukesha, WI Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	0.9664
5120	Minneapolis-St. Paul, MN-WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Sherburne, MN Washington, MN Wright, MN Pierce, WI St. Croix, WI	1.0971
5140	Missoula, MT Missoula, MT	0.9274
5160	Mobile, AL Baldwin, AL Mobile, AL	0.8006
5170	Modesto, CA Stanislaus, CA	1.0401
5190	Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.1293
5200	Monroe, LA Ouachita, LA	0.8316

5240	Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.7642
5280	Muncie, IN Delaware, IN	1.0683
5330	Myrtle Beach, SC Horry, SC	0.8440
5345	Naples, FL Collier, FL	0.9661
5360	Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN	0.9327
5380	Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.3784
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2192
5523	New London-Norwich, CT New London, CT	1.2061
5560	New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9235

5600	New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.4483
5640	Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1828
5660	Newburgh, NY-PA Orange, NY Pike, PA	1.0847
5720	Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA 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	0.8374
5775	Oakland, CA Alameda, CA Contra Costa, CA	1.5029
5790	Ocala, FL Marion, FL	0.9243
5800	Odessa-Midland, TX Ector, TX Midland, TX	0.9206

5880	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8774
5910	Olympia, WA Thurston, WA	1.0689
5920	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9470
5945	Orange County, CA Orange, CA	1.1453
5960	Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9550
5990	Owensboro, KY Daviess, KY	0.8159
6015	Panama City, FL Bay, FL	0.9010
6020	Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8258
6080	Pensacola, FL Escambia, FL Santa Rosa, FL	0.8176
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8494

6160	Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0753
6200	Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	0.9628
6240	Pine Bluff, AR Jefferson, AR	0.7771
6280	Pittsburgh, PA Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.9570
6323	Pittsfield, MA Berkshire, MA	1.0130
6340	Pocatello, ID Bannock, ID	0.9076
6360	Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.4993
6403	Portland, ME Cumberland, ME Sagadahoc, ME York, ME	0.9687
6440	Portland-Vancouver, OR-WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.0913

6483	Providence-Warwick-Pawtucket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.0771
6520	Provo-Orem, UT Utah, UT	1.0014
6560	Pueblo, CO Pueblo, CO	0.8783
6580	Punta Gorda, FL Charlotte, FL	0.9602
6600	Racine, WI Racine, WI	0.9231
6640	Raleigh-Durham-Chapel Hill, NC Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	0.9583
6660	Rapid City, SD Pennington, SD	0.8779
6680	Reading, PA Berks, PA	0.9105
6690	Redding, CA Shasta, CA	1.1641
6720	Reno, NV Washoe, NV	1.0550
6740	Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.1460

6760	Richmond-Petersburg, VA Charles City County, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA	0.9618
6780	Riverside-San Bernardino, CA Riverside, CA San Bernardino, CA	1.1229
6800	Roanoke, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.8663
6820	Rochester, MN Olmsted, MN	1.1334
6840	Rochester, NY Genesee, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.8991
6880	Rockford, IL Boone, IL Ogle, IL Winnebago, IL	0.8819
6895	Rocky Mount, NC Edgecombe, NC Nash, NC	0.8849
6920	Sacramento, CA El Dorado, CA Placer, CA Sacramento, CA	1.1932

6960	Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	0.9557
6980	St. Cloud, MN Benton, MN Stearns, MN	0.9994
7000	St. Joseph, MO Andrews, MO Buchanan, MO	0.9071
7040	St. Louis, MO-IL 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	0.8947
7080	Salem, OR Marion, OR Polk, OR	1.0189
7120	Salinas, CA Monterey, CA	1.4518
7160	Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	0.9782
7200	San Angelo, TX Tom Green, TX	0.8083
7240	San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.8540
7320	San Diego, CA San Diego, CA	1.1784

7360	San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.4250
7400	San Jose, CA Santa Clara, CA	1.3759
7440	San Juan-Bayamon, PR 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	0.4651
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.0673
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0580
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.4040

7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0538
7500	Santa Rosa, CA Sonoma, CA	1.2649
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9809
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9601
7560	Scranton--Wilkes-Barre--Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8401
7600	Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.0985
7610	Sharon, PA Mercer, PA	0.7900
7620	Sheboygan, WI Sheboygan, WI	0.8379
7640	Sherman-Denison, TX Grayson, TX	0.8694
7680	Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.8705
7720	Sioux City, IA-NE Woodbury, IA Dakota, NE	0.8471
7760	Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.8790
7800	South Bend, IN St. Joseph, IN	0.9848
7840	Spokane, WA Spokane, WA	1.0496
7880	Springfield, IL Menard, IL Sangamon, IL	0.8656

7920	Springfield, MO Christian, MO Greene, MO Webster, MO	0.8484
8003	Springfield, MA Hampden, MA Hampshire, MA	1.0485
8050	State College, PA Centre, PA	0.9022
8080	Steubenville-Weirton, OH-WV Jefferson, OH Brooke, WV Hancock, WV	0.8548
8120	Stockton-Lodi, CA San Joaquin, CA	1.0606
8140	Sumter, SC Sumter, SC	0.8271
8160	Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9378
8200	Tacoma, WA Pierce, WA	1.1553
8240	Tallahassee, FL Gadsden, FL Leon, FL	0.8482
8280	Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.8960
8320	Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8268
8360	Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.8341
8400	Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9742
8440	Topeka, KS Shawnee, KS	0.9051

8480	Trenton, NJ Mercer, NJ	1.0113
8520	Tucson, AZ Pima, AZ	0.8785
8560	Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8480
8600	Tuscaloosa, AL Tuscaloosa, AL	0.8064
8640	Tyler, TX Smith, TX	0.9340
8680	Utica-Rome, NY Herkimer, NY Oneida, NY	0.8547
8720	Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.2849
8735	Ventura, CA Ventura, CA	1.1040
8750	Victoria, TX Victoria, TX	0.8154
8760	Vineland-Millville-Bridgeton, NJ Cumberland, NJ	1.0501
8780	Visalia-Tulare-Porterville, CA Tulare, CA	0.9551
8800	Waco, TX McLennan, TX	0.8253

8840	Washington, DC-MD-VA-WV 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	1.0711
8920	Waterloo-Cedar Falls, IA Black Hawk, IA	0.8404
8940	Wausau, WI Marathon, WI	0.9418
8960	West Palm Beach-Boca Raton, FL Palm Beach, FL	0.9699
9000	Wheeling, OH-WV Belmont, OH Marshall, WV Ohio, WV	0.7665
9040	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS	0.9502
9080	Wichita Falls, TX Archer, TX Wichita, TX	0.7647
9140	Williamsport, PA Lycoming, PA	0.8332

9160	Wilmington-Newark, DE-MD New Castle, DE Cecil, MD	1.0826
9200	Wilmington, NC New Hanover, NC Brunswick, NC	0.9394
9260	Yakima, WA Yakima, WA	0.9876
9270	Yolo, CA Yolo, CA	1.0199
9280	York, PA York, PA	0.9196
9320	Youngstown-Warren, OH Columbiana, OH Mahoning, OH Trumbull, OH	0.9477
9340	Yuba City, CA Sutter, CA Yuba, CA	1.0706
9360	Yuma, AZ Yuma, AZ	0.9529

Table 3B.--Wage Index for Rural Areas

Nonurban Area	Wage Index
Alabama	0.7483
Alaska	1.2380
Arizona	0.8309
Arkansas	0.7444
California	0.9857
Colorado	0.8967
Connecticut	1.1715
Delaware	0.9058
Florida	0.8918
Georgia	0.8326
Guam	.....
Hawaii	1.1053
Idaho	0.8650
Illinois	0.8152
Indiana	0.8602
Iowa	0.8000
Kansas	0.7574
Kentucky	0.7921
Louisiana	0.7655
Maine	0.8736
Maryland	0.8651
Massachusetts	1.1205
Michigan	0.8969
Minnesota	0.8864
Mississippi	0.7481
Missouri	0.7693
Montana	0.8679

Nebraska	0.8055
Nevada	0.9228
New Hampshire	0.9741
New Jersey 1/	.....
New Mexico	0.8495
New York	0.8472
North Carolina	0.8437
North Dakota	0.7676
Ohio	0.8663
Oklahoma	0.7484
Oregon	1.0124
Pennsylvania	0.8535
Puerto Rico	0.4264
Rhode Island 1/	.....
South Carolina	0.8369
South Dakota	0.7550
Tennessee	0.7836
Texas	0.7490
Utah	0.9029
Vermont	0.9266
Virginia	0.8181
Virgin Islands	.....
Washington	1.0422
West Virginia	0.8206
Wisconsin	0.8865
Wyoming	0.8805

1/ All counties within the State are classified urban.

APPENDIX A--Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data files used to develop the final IRF prospective payment system. A general description of the process to create this data file is contained in section III.B. of this final rule. RAND has performed the following analysis to match FIM data (that is, collectively, patient assessment data from the Uniform Data System for medical rehabilitation (UDSmr) (1996 through 1999); the Caredata Data System (COS) for medical rehabilitation (1996 and 1997); and the HealthSouth Corporation (HS) (1998 and 1999)) and our Medicare data files.

Table A shows that, for 1996 through 1999, the MedPAR files had over 12 million records per year. We are interested in a subset of these records: cases paid by Medicare as rehabilitation stays that were excluded from the acute care hospital prospective payment system.

Table A.--Number of MedPAR Cases and Facilities

Calendar Year	Number of Cases	Number of Facilities
1996	12,231,275	6,339
1997	12,263,463	6,257
1998	12,266,445	6,235
1999	12,073,949	6,223

Table B shows total 1996 through 1999 rehabilitation stays by type of provider (freestanding rehabilitation facility versus excluded unit of an acute care hospital). This was the "sampling" frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining "complete" records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would be representative of the 1996 through 1999 rehabilitation stays in the "sampling" frames.

Table B.--Number of Rehabilitation MedPAR Cases and Facilities

Calendar Year	Type	Number of Cases	Number of Facilities	Total Number of Cases	Total Number of Facilities
1996	Excluded Unit	229,193	877	344,126	1,081
	Freestanding	114,933	204		
1997	Excluded Unit	240,491	911	359,032	1,123
	Freestanding	118,541	212		
1998	Excluded Unit	248,015	941	370,352	1,155
	Freestanding	122,337	214		
1999	Excluded Unit	260,745	961	390,048	1,165
	Freestanding	129,303	204		

Note: Freestanding facilities have characters 3-6 of the Medicare provider number in the range 3025-3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a "provider code" of T in their MedPAR records.

Table C shows the number of facilities and the number of FIM records for calendar years 1996 through 1999. Our sources for 1996 and 1997 were UDSmr and COS. For 1998 and 1999, we used UDSmr data and data from Caredata's principal client, HealthSouth Corporation. (Caredata ceased to exist prior to our getting its 1998 and 1999 data.) Our tables combine data from the different sources to preserve confidentiality.

Table C.--Number of FIM Records and Facilities, By Year

Calendar Year	Sources	Number of Records	Number of Facilities*
1996	UDSmr/COS	269,547	692
1997	UDSmr/COS	326,265	759
1998	UDSmr/HS	343,004	751
1999	UDSmr/HS	381,453	766

*For the discussion that follows, consider facilities as distinct entities within a FIM source. We adjust our counts later for possible overlap and double counting.

Matching MedPAR and FIM Facilities

The first step in the matching process is to link MedPAR facilities to FIM facilities. For each of these combinations, RAND counted the number of exact matches of MedPAR and FIM records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our FIM data sets is slightly more than half of all IRFs.

Table D.--Numbers of FIM Facilities Linked to MedPAR Facilities

Calendar Year	Sources	MedPAR Unique[a]	MedPAR Multiple[b]	MedPAR Nonmatch[c]	Total
1996	UDSmr/COS	568	18	106	692
1997	UDSmr/COS	625	33	101	759
1998	UDSmr/HS	730	19	2	751
1999	UDSmr/HS	729	35	2	766

[a]FIM IRFs that appear to have a single MedPAR provider.
[b]FIM IRFs that appear to have more than one MedPAR provider.
[c]FIM IRFs that did not link to our Medicare files. The large drop between 1997 and 1998 is because SNF and long-term care hospital data were excluded from our 1998/1999 request.

The FIM data do not contain the Medicare beneficiary identifier and, therefore, it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

(1) Identify match variables;

(2) Recode certain FIM variables to be consistent with MedPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;

(3) Run a match algorithm to link FIM and MedPAR records; and

(4) Choose a single MedPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility identifier pairings was performed. An attempt was made to match all MedPAR records to a FIM record for all facilities.

For MedPAR, in addition to facility identity, six variables were used to link the records: admission date, discharge date, zip code, age at admission, sex, and race. For FIM, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payer was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create/Delete FIM Records

COS and HS coded interrupted stays in a manner similar to Medicare: one record per rehabilitation discharge episode. Therefore, these records did not require any additional processing. However, UDSmr codes multiple stays via a series of "transfer/return" dates on a single UDSmr record. To facilitate matching UDSmr and MedPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records

were then given the same chance of matching MedPAR records as any noninterrupted stay.

For UDSmr, COS, and HS files, there were some duplicate cases that had to be eliminated.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MedPAR.

Table E.--Number of FIM Records At Various Stages of Processing

Calendar Year	Source	Number of Records		
		Original	After Expansion	After Duplicate Elimination
1996	UDSmr/COS	269,547	276,554	275,378
1997	UDSmr/COS	326,265	334,794	333,370
1998	UDSmr/HS	343,004	352,602	352,469
1999	UDSmr/HS	381,453	391,820	391,627

Step 3: Match Discharges from MedPAR and FIM Facilities

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect--any variable can be in error. A scoring function was developed, based on Bayes' Theorem, which gives the odds of a match based on how consistent variables tend to be for true matching and nonmatching cases.

The scoring function selects pairs with the greatest likelihood of being correct matches. A cutoff under which scores below are considered "nonmatches" and scores above are considered "matches" is chosen empirically. We sorted the pairings by score, and examined candidate matches as a function of this score. We wanted a conservative criterion--agreement between two "matched" records not likely to be resulting from chance. We noticed that cases in the 3.2 range and above appeared to be the same: race and sex agreeing, mild disagreement between usually at most one of the other match variables (admission date, discharge date, age, and zip code). We also looked at additional variables not employed in the matching process. For cases above the 3.2 threshold, a FIM variable tended to indicate that Medicare was the "primary payer," and the Medicare provider code tended to be "T" in acute care hospitals; both were less likely below 3.2. Thus, we chose 3.2 as our cutoff.

Step 4: Choose a Single MedPAR Case for Multiple FIM Matches

While the matching was unique within a facility/provider pair, some MedPAR providers were paired with different facilities, as shown in Table F. Also, some

UDSmr and COS/HS facilities were the same: 6 overlaps in 1996, 7 in 1997, 26 in 1998, and 1 in 1999.

Table F.--MedPAR Facilities Paired with Multiple Facilities

Calendar Year	Sources	Number of Facilities
1996	UDSmr	5
	COS	5
1997	UDSmr	8
	COS	10
1998	UDSmr	10
	HS	0
1999	UDSmr	18
	HS	0

Each nonunique pairing had the potential of creating multiple matches to a single MedPAR record. We eliminated these matches in two steps. First, working within each UDSmr, COS, and HS file, we eliminated MedPAR duplicate links, keeping the match with the highest score. Then we checked for duplicate links between UDSmr and the corresponding COS/HS files within the same year, again keeping the match with the highest score. Table G provides results for cutoff score 3.2, as discussed in Step 3.

Table G.--Number of Linked Records After Duplicates Elimination

Calendar Year	Sources	Number of Records		
		Total Records	Duplicates Eliminated[1]	Overlap Eliminated[2]
1996	UDSmr/COS	191,173	190,480	188,889
1997	UDSmr/COS	227,696	226,411	222,682
1998	UDSmr/HS	252,662	247,296	246,450
1999	UDSmr/HS	281,230	273,772	273,548

[1]Multiple pairings can link the same MedPAR record to more than one FIM case. This step eliminates those multiple links, keeping the link with the highest match score.
[2]The same MedPAR provider might show up in both UDSmr and COS, again allowing the same MedPAR record to match more than one FIM case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: FIM and MedPAR, by year. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these FIM facilities for the eligible population in the IRF prospective payment system to be almost 90 percent. This

was slightly higher than expected--the Carter, Relles, et al. (1997) match rates were about 86 percent.

Table H.--MedPAR Match Rates, Providers with a Full Year of Data

Calendar Year	Sources	MedPAR Cases	Matched Cases	Percent Matched
1996	UDSmr/COS	162,659	142,410	87.6
1997	UDSmr/COS	212,581	190,069	89.4
1998	UDSmr/HS	234,623	208,769	89.0
1999	UDSmr/HS	263,785	237,568	90.1

Note: Tabulations are for patients eligible for IRF prospective payment system.

The FIM files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Accordingly, restricting our attention to Medicare cases, we obtain the percentages shown in Table I.

Table I.--FIM Match Rates for Medicare as the Primary Payer

Calendar Year	Source	FIM Cases	Matched Cases	Percent Matched
1996	UDSmr/COS	188,892	180,783	95.7
1997	UDSmr/COS	223,351	213,053	95.4
1998	UDSmr/HS	246,727	235,261	95.4
1999	UDSmr/HS	273,303	261,969	95.9

Note: FIM cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these

match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MedPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in freestanding facilities differed from costs in excluded units of acute care hospitals, we would consider re-weighting the sample of linked cases to adjust our total cost estimates.

Tables J through N present an analysis of the characteristics of the facilities and cases in the matched sample described in the previous tables. The data in Tables J through N are the latest data available for the purposes of constructing a data file used to develop the IRF prospective payment system in this final rule.

Representativeness of Linked MedPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the FIM file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare beneficiaries, and the extent to which FIM patients are representative of all

Medicare eligible patients under the IRF prospective payment system. This analysis reflects the effects of the partial-year sample available for some FIM facilities as well as the sampling of MedPAR facilities. The MedPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into freestanding rehabilitation facilities (freestanding rehabilitation) and excluded rehabilitation units of acute-care hospitals (excluded units). It presents the number of facilities in the linked MedPAR sample, along with the total MedPAR counts of rehabilitation patients at these facilities.

Table J.--Comparison of Number of FIM and MedPAR Rehabilitation Facilities, by Type

Year	Type of Facility	Number of Facilities			Number of Rehabilitation Patients		
		FIM[a]	Total MedPAR[b]	Percent FIM	FIM[a]	Total MedPAR[b]	Percent FIM
1996	Freestanding Rehabilitation	130	204	64	86,301	114,933	75
	Excluded Unit	435	877	50	130,623	229,193	57
	Total	565	1,081	42	216,924	344,126	63
1997	Freestanding Rehabilitation	142	212	67	94,327	118,541	80
	Excluded Unit	489	911	54	150,787	240,491	63
	Total	631	1,123	56	245,114	359,032	68
1998	Freestanding Rehabilitation	171	214	80	111,503	122,337	91
	Excluded Unit	515	941	55	157,483	248,015	63
	Total	686	1,155	59	268,986	370,352	73
1999	Freestanding Rehabilitation	170	204	83	120,284	129,303	93
	Excluded Unit	554	961	58	171,886	260,745	66
	Total	724	1,165	62	292,170	390,048	75

[a]Hospitals with at least one linked MedPAR/ FIM rehabilitation record.
[b]Total (matched and unmatched) rehabilitation cases.

As shown in Table J, for 1999, FIM facilities represented 62 percent of the facilities, but served almost 75 percent of all MedPAR IRF cases. Based on data found in the table, in 1999, FIM freestanding facilities had an average of 708 patients, 442 more than other-MedPAR freestanding facilities; and FIM excluded units had an average of 310 patients, 92 more than other-MedPAR excluded units.

Table K shows the distribution of FIM IRFs by size. This shows both that freestanding facilities are larger than excluded units and that FIM IRFs tend to be larger than other MedPAR facilities within type of facility.

Table K.--Comparison of Sizes of FIM and MedPAR Facilities, by Type of Facility

Number of MedPAR Patients	1996				1997			
	Freestanding		Excluded Unit		Freestanding		Excluded Unit	
	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR
1-100	2	23	30	97	4	24	33	105
101-200	14	9	139	140	14	7	143	126
201-300	14	2	105	102	11	5	123	103
301-400	14	10	59	48	17	9	65	40
401-500	8	8	38	27	12	7	52	29
501-1000	56	16	58	26	59	15	67	18
1001-2000	20	6	6	2	24	3	6	1
2001-3000	1	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	**130**	**74**	**435**	**442**	**142**	**70**	**489**	**422**
	1998				**1999**			
1-100	6	19	50	115	3	13	57	100
101-200	14	9	136	125	10	9	148	115
201-300	11	5	130	82	12	5	130	85
301-400	18	2	78	52	15	1	79	63
401-500	17	2	51	28	20	1	66	26
501-1000	80	3	60	24	76	2	62	17
1001-2000	24	3	10	0	33	3	12	1
2001-3000	0	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	**171**	**43**	**515**	**426**	**170**	**34**	**554**	**407**

Table L shows the percentage of cases in FIM facilities in each State.

Table L.--Number and Percentage of MedPAR Rehabilitation Cases For FIM Sample Hospitals, by State

STATE	MedPAR Rehabilitation Cases				Percent of Cases in FIM Hospital Sample			
	1996	1997	1998	1999	1996	1997	1998	1999
AL	7,839	8,654	8,855	8,667	91	96	79	81
AK	247	302	280	301	55	51	56	55
AR	6,581	6,973	8,349	9,626	43	48	63	65
AZ	3,672	4,084	4,436	5,244	62	57	63	67
CA	15,294	15,559	15,579	16,936	53	51	56	58
CO	4,757	4,263	4,035	3,946	27	65	33	69
CT	2,217	2,290	1,901	1,989	69	88	90	89
DC	1,097	996	1,076	1,167	12	10	8	20
DE	1,399	1,361	1,375	1,628	76	72	70	66
FL	23,021	23,630	24,058	24,741	74	79	91	90
GA	9,615	10,716	10,874	11,062	64	65	66	68
HI	1,087	1,016	831	696	100	100	100	100
IA	1,264	1,404	1,324	1,579	100	100	98	100
ID	1,829	1,807	1,782	1,903	97	98	97	97
IL	14,953	14,894	14,720	16,111	54	62	60	62
IN	8,943	8,884	9,301	9,683	60	60	83	86
KS	3,224	3,333	3,647	4,074	27	24	64	72
KY	5,198	5,201	5,653	6,489	74	79	86	80
LA	9,206	10,061	10,292	11,079	36	50	68	67
MA	8,765	8,631	8,973	9,582	52	67	77	78
MD	867	715	767	782	77	80	80	86
ME	1,255	1,460	1,629	1,873	10	72	79	80
MI	16,523	17,255	18,157	18,797	82	82	80	81
MN	2,048	2,112	2,508	2,594	54	74	49	49
MO	9,788	10,513	10,677	11,009	34	42	58	62
MS	1,968	2,021	2,050	2,442	86	86	85	83
MT	878	766	652	681	100	100	100	100
NC	7,123	8,771	9,588	9,912	89	88	97	98
ND	1,821	1,636	1,627	1,697	86	83	73	71
NE	1,195	1,107	1,143	1,083	92	91	89	88
NH	2,310	2,505	2,435	2,375	57	58	77	75
NJ	11,234	11,083	11,172	11,988	89	96	93	99
NM	1,283	1,277	1,355	1,537	28	35	40	45
NV	2,230	2,303	2,855	3,471	0	0	52	51
NY	21,431	22,875	25,755	26,271	37	51	58	72
OH	11,837	13,888	13,683	13,938	76	73	75	71
OK	6,356	6,949	7,757	8,716	51	59	58	54
OR	1,179	1,184	1,198	1,173	70	61	74	75
PA	36,989	35,700	34,201	35,552	63	69	71	73
RI	2,247	2,307	1,771	1,460	61	66	100	100
SC	4,536	4,878	5,691	6,182	83	86	83	82
SD	2,096	2,101	2,031	2,071	80	81	79	78
TN	10,731	11,917	12,317	12,744	71	71	72	76

STATE	MedPAR Rehabilitation Cases				Percent of Cases in FIM Hospital Sample			
	1996	1997	1998	1999	1996	1997	1998	1999
TX	33,619	36,616	38,871	40,387	58	62	70	72
UT	858	984	1,044	1,673	43	62	57	65
VA	6,738	7,235	7,544	7,671	73	78	70	73
VT	603	567	582	691	74	73	68	75
WA	3,753	3,608	3,598	3,918	99	99	99	91
WI	6,591	6,690	6,468	6,643	87	93	89	89
WV	3,497	3,574	3,467	3,899	100	99	99	100
WY	334	376	418	315	31	75	23	49
Total	344,126	359,032	370,352	390,048	63	68	73	75

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched FIM sample. Of all the characteristics examined, the FIM sample of discharges appears very similar.

Table M.--Patient Characteristics for MedPAR Rehabilitation Inpatients, by FIM Status

PATIENT CHARACTERISTIC	FIM	OTHER MedPAR	TOTAL MedPAR	FIM	OTHER MedPAR	TOTAL MedPAR
	1996			1997		
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0-50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51-60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61-70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71-80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81-90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%
	1998			1999		
Sample Size	232,691	137,661	370,352	257,024	133,024	390,048
Average Age	75.5	75.7	75.6	75.8	76.0	75.9
Age 0-50	2.8%	2.9%	2.8%	2.8%	2.8%	2.8%
Age 51-60	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%
Age 61-70	18.9%	18.4%	18.7%	18.1%	17.8%	18.0%
Age 71-80	43.6%	42.1%	43.0%	42.8%	41.5%	42.3%
Age 81-90	27.8%	28.8%	28.2%	28.9%	29.9%	29.2%
Age 91+	3.6%	4.2%	3.8%	3.9%	4.5%	4.1%
Male	37.9%	37.3%	37.7%	37.6%	37.2%	37.4%
White	86.5%	84.8%	85.9%	86.6%	84.8%	86.0%
Black	10.1%	10.8%	10.4%	9.8%	10.8%	10.2%
In-hospital death	0.3%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked FIM stays with those for other Medicare rehabilitation patients. Average length of stay for FIM cases is the same as for non-FIM patients in 1996 and 1997, but is higher for FIM patients in 1998 and 1999. For cases in freestanding hospitals, FIM stays consume fewer resources in the first half of the data period, but not in the second half.

During this time, the FIM database grew from 75 percent to 93 percent of all freestanding cases.

Table N.--Comparison of Resource Use for Medicare Rehabilitation Inpatients, by FIM Status

		All Hospitals			Freestanding Hospitals		
Year	Hospitalization Characteristic	FIM	OTHER MedPAR	TOTAL MedPAR	FIM	OTHER MedPAR	TOTAL MedPAR
1996	Sample size	171,626	172,500	344,126	65,349	49,584	114,933
	Length of Stay (days)	16.2	16.2	16.2	18.0	18.9	18.4
	Daily therapy charges	$360	$351	$355	$360	$387	$371
	Total therapy charges	$5,960	$5,829	$5,894	$6,652	$7,605	$7,063
	Total charges	$18,013	$18,790	$18,403	$19,443	$21,214	$20,207
1997	Sample size	206,032	153,000	359,032	82,393	36,148	118,541
	Length of Stay (days)	15.7	15.7	15.7	17.8	19.2	18.2
	Daily therapy charges	$379	$368	$374	$384	$406	$391
	Total therapy charges	$6,064	$5,924	$6,004	$7,002	$8,064	$7,325
	Total charges	$18,348	$19,287	$18,748	$20,202	$22,541	$20,915
1998	Sample size	232,691	137,661	370,352	96,262	26,075	122,337
	Length of Stay (days)	15.8	14.6	15.3	18.2	17.1	18.0
	Daily therapy charges	$396	$383	$391	$398	$414	$402
	Total therapy charges	$6,361	$5,676	$6,106	$7,458	$7,285	$7,421
	Total charges	$19,230	$19,090	$19,178	$21,129	$21,558	$21,220
1999	Sample size	257,024	133,024	390,048	108,290	21,013	129,303
	Length of Stay (days)	15.4	14.0	14.9	17.8	16.1	17.5
	Daily therapy charges	$425	$409	$419	$428	$436	$430
	Total therapy charges	$6,621	$5,843	$6,355	$7,789	$7,231	$7,698
	Total charges	$20,000	$19,359	$19,781	$21,821	$21,449	$21,761

Note: FIM case totals count matched cases; hence, they differ from the total in Table J, which counts matched and unmatched cases.