

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1290-F]

RIN 0938-AN43

Medicare Program; Inpatient Rehabilitation Facility

Prospective Payment System for FY 2006

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

ACTION: Final rule.

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

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

EFFECTIVE DATE: The updated IRF prospective payment rates are effective for [discharges on or after October 1, 2005 and on or before September 30, 2006 (FY 2006)].

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Zinnia Ng, (410) 786-4587 for information regarding the wage index and Core-Based Statistical Areas (CBSAs).

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- Acronyms**

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

ADC	Average Daily Census
AHA	American Hospital Association
AMI	Acute Myocardial Infarction
BBA	Balanced Budget Act of 1997 (BBA), Pub. L. 105-33
BBRA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106-113
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106-554
BLS	Bureau of Labor Statistics
CART	Classification and Regression Trees
CBSA	Core-Based Statistical Areas
CCR	Cost-to-charge ratio
CMGs	Case-Mix Groups
CMI	Case Mix Index
CMSA	Consolidated Metropolitan Statistical Area
CPI	Consumer Price Index
DSH	Disproportionate Share Hospital
ECI	Employment Cost Index
FI	Fiscal Intermediary

FIM	Functional Independence Measure (FIM™ is a registered trademark of UDS _{MR})
FIM-FRGs	Functional Independence Measures-Function Related Groups
FRG	Function Related Group
FTE	Full-time equivalent
FY	Federal Fiscal Year
GME	Graduate Medical Education
HCRIS	Healthcare Cost Report Information System
HIPAA	Health Insurance Portability and Accountability Act
HHA	Home Health Agency
IME	Indirect Medical Education
IFMC	Iowa Foundation for Medical Care
IPF	Inpatient Psychiatric Facility
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
IRF-PPS	Inpatient Rehabilitation Facility-Prospective Payment System
IRVEN	Inpatient Rehabilitation Validation and Entry
LIP	Low-income percentage
MEDPAR	Medicare Provider Analysis and Review
MSA	Metropolitan Statistical Area

NECMA	New England County Metropolitan Area
NOS	Not Otherwise Specified
NTIS	National Technical Information Service
OMB	Office of Management and Budget
OSCAR	Online Survey, Certification, and Reporting
PAI	Patient Assessment Instrument
PLI	Professional Liability Insurance
PMSA	Primary Metropolitan Statistical Area
PPI	Producer Price Index
PPS	Prospective Payment System
RIC	Rehabilitation Impairment Category
RPL	Rehabilitation Hospital, Psychiatric Hospital, and Long-Term Care Hospital Market Basket
TEFRA	Tax Equity and Fiscal Responsibility Act
TEP	Technical Expert Panel

I. Background

We received approximately 55 timely items of correspondence on the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006 proposed rule (70 FR 30188). Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule.

A. General Overview of the Current Inpatient

Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 4421 of the Balanced Budget Act of 1997 (BBA)

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

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

The IRF PPS, as described in the August 7, 2001 final rule, uses Federal prospective payment rates across 100 distinct case-mix groups (CMGs). Ninety-five CMGs were constructed using rehabilitation impairment categories, functional status (both motor and cognitive), and age (in

some cases, cognitive status and age may not be a factor in defining a CMG). Five special CMGs were constructed to account for very short stays and for patients who expire in the IRF.

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

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

will refer to the standardized payment amount in this final rule as the standard payment conversion factor.

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

Lastly, the IRF's final prospective payment amount was determined under the transition methodology prescribed in section 1886(j) of the Act. Specifically, for cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, section 1886(j)(1) of the Act and as specified in §412.626 provide that IRFs transitioning into the PPS would receive a "blended payment." For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, these blended payments consisted of 66 2/3 percent of the Federal IRF PPS rate and 33 1/3 percent of the payment that the IRF would have been paid had the IRF PPS not been implemented. However, during the transition period, an IRF with a cost reporting period

beginning on or after January 1, 2002 and before October 1, 2002 could have elected to bypass this blended payment and be paid 100 percent of the Federal IRF PPS rate.

For cost reporting periods beginning on or after October 1, 2002 (FY 2003), the transition methodology expired, and payments for all IRFs consist of 100 percent of the Federal IRF PPS rate.

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

B. Requirements for Updating the Prospective Payment Rates for IRFs

On August 7, 2001, we published a final rule entitled "Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities" in the **Federal Register** (66 FR at 41316), that established a PPS for IRFs as authorized under section 1886(j) of the Act and codified at subpart P of part 412 of the Medicare regulations. In the August 7, 2001 final rule, we set forth the per discharge Federal prospective payment rates for fiscal year (FY) 2002 that provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of

approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS.

The provisions of the August 7, 2001 final rule were effective for cost reporting periods beginning on or after January 1, 2002. On July 1, 2002, we published a correcting amendment to the August 7, 2001 final rule in the **Federal Register** (67 FR at 44073). Any references to the August 7, 2001 final rule in this final rule include the provisions effective in the correcting amendment.

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

We published a proposed rule in the **Federal Register** (70 FR 30189) to update the IRF Federal prospective payment rates from FY 2005 to FY 2006, and we proposed revisions to the methodology described in §412.624.

C. Operational Overview of the Current IRF PPS

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

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

Once the patient is discharged, the IRF completes the

Medicare claim (UB-92 or its equivalent) using an alphanumeric CMG code and sends it to the appropriate Medicare fiscal intermediary (FI). (Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA), Pub. L. 107-105, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191. Section 3 of ASCA requires the Medicare Program, subject to subsection (H), to deny payment under Part A or Part B for any expenses for items or services "for which a claim is submitted other than in an electronic form specified by the Secretary." Subsection (h) provides that the Secretary shall waive such denial in two types of cases and may also waive such denial "in such unusual cases as the Secretary finds appropriate." See also, 68 FR 48805 (August 15, 2003). Section 3 of ASCA operates in the context of the Administrative Simplification provisions of HIPAA, which include, among others, the transactions and code sets standards requirements codified as 45 CFR part 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered providers, to conduct covered electronic transactions according to the applicable transaction standards. See the program claim memoranda issued and published by CMS at

www.cms.hhs.gov/providers/edi/default.asp

<<http://www.cms.hhs.gov/provider/edi/default.asp>> and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in section 3604 of Part 3 of the Medicare Intermediary Manual.

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

D. Summary of the FY 2006 Proposed Update to the IRF PPS

In the FY 2006 proposed rule (70 FR 30188), we proposed a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. The refinements that we proposed were based on analyses by RAND using calendar year 2002 and FY 2003 data.

Several new developments warranted proposing these refinements, including--(1) the availability of more recent

2002 and 2003 data; (2) better coding of comorbidities and patient severity; (3) more complete data; (4) new data sources for imputing missing values; and (5) improved statistical approaches.

Our proposals included the following key changes:

The FY 2006 IRF PPS proposed rule (70 FR 30188, 30234 through 30241) included a proposal to adopt OMB's Core Based Statistical Area (CBSA) market area definitions in a budget neutral manner. This geographic adjustment is made using a 1-year lag of the pre-reclassification hospital wage index (FY 2001 hospital wage data).

The FY 2006 proposed rule (70 FR 30188, 30222) also included a proposal to implement a payment adjustment to account for changes in coding. We proposed to reduce the standard payment amount by 1.9 percent to account for changes in coding following implementation of the IRF PPS. The analysis conducted by CMS's contractor found that the real change in the case-mix was between negative 2.4 percent and positive 1.5 percent, with the rest of the change (between 1.9 percent and 5.8 percent) attributable to coding changes. CMS proposed to reduce the standard payment amount by the lowest of these estimates.

In addition, in the FY 2006 proposed rule (70 FR 30188), we proposed modifications to the case mix groups, tier comorbidities, and relative weights. The

proposed rule included a number of adjustments to the IRF classification system that are designed to improve the system's ability to predict IRF costs. The new data indicate that moving or eliminating some comorbidity codes from the tiers, redefining the case mix groups, and other minor changes to the system could improve the ability of the classification system to ensure that Medicare payments to IRFs continue to be aligned with the costs of care.

In addition, the FY 2006 IRF PPS proposed rule (70 FR 30188, 30241) contained a proposal to implement a new teaching status adjustment for IRFs, similar to the one recently adopted for inpatient psychiatric facilities. We proposed to implement the teaching status adjustment in a budget neutral manner.

The FY 2006 IRF PPS proposed rule (70 FR 30188, 30222) also contained a proposal to revise the market basket. We proposed to use a new market basket reflecting the operating and capital cost structures for rehabilitation, psychiatric, and long term care hospitals to update IRF payment rates. The proposed new market basket excludes cancer hospitals and children's hospitals. For the FY 2006 proposed rule (70 FR 30188), we proposed a market basket increase for FY 2006 of 3.1 percent.

In the FY 2006 proposed rule (70 FR 30188, 30244 through 30246), we also proposed to update the rural

adjustment (from 19.1 percent to 24.1 percent), the low-income patient adjustment (from an exponent of 0.484 to an exponent of 0.636), and the outlier threshold amount (from \$11,211 to \$4,911). We proposed to implement the changes to the rural and low-income percentage updates in a budget neutral manner.

Lastly, in the FY 2006 proposed rule (70 FR 30188), we estimated that the proposed changes would increase costs to the Medicare program for IRF services in FY 2006 by \$180 million over FY 2005 levels. The estimated increased cost to the Medicare program was due to the estimated IRF market basket of 3.1 percent, the 1.9 percent reduction to the standard payment amount to account for changes in coding that affect total estimated aggregate payments, and the update to the outlier threshold amount. We proposed to make the changes to the IRF labor-related share and the wage indices, the case mix groups, tier comorbidities, and relative weights, the new IME adjustment, the updated rural adjustment, and the updated LIP adjustment in a budget neutral manner. Thus, these proposed changes would have no overall effect on estimated costs to the Medicare program.

II. Provisions of the Proposed Regulations

In the FY 2006 proposed update to the IRF PPS (70 FR 30188), hereinafter referred to as the FY 2006 proposed rule, we proposed to make revisions to the

regulations to implement the proposed PPS for IRFs for FY 2006 and subsequent fiscal years. Specifically, we proposed to make conforming changes in 42 CFR part 412. These proposed revisions and others are discussed in detail below.

A. Section 412.602 Definitions

In §412.602, we proposed to revise the definitions of "Rural area" and "Urban area" to read as follows:

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

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

B. Section 412.622 Basis of payment

In this section, we proposed to correct the cross references in paragraphs (b)(1) and (b)(2)(i). In paragraph (b)(1), we proposed to remove the cross references "§413.85

and §413.86 of this chapter” and add in their place “§413.75 and §413.85 of this chapter.” In paragraph (b)(2)(i), we proposed to remove the cross reference “§413.80 of this chapter” and add in its place “§413.89 of this chapter.”

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

In this section, we proposed to make the following revisions:

- In paragraph (d)(1), remove the cross reference to “paragraph (e)(4)” and add in its place “paragraph (e)(5).”
- Add a new paragraph (d)(4).
- Redesignate paragraphs (e)(4) and (e)(5) as paragraphs (e)(5) and (e)(6).
- Add a new paragraph (e)(4).
- Revise newly redesignated paragraph (e)(5).
- Revise newly redesignated paragraph (e)(6).
- Add a new paragraph (e)(7).
- In paragraph (f)(2)(v), remove the cross references to “paragraphs (e)(1), (e)(2), and (e)(3) of this section” and add in their place “paragraphs (e)(2), (e)(3), (e)(4), and (e)(7) of this section.”

D. Additional Changes

We also proposed the following changes:

- Reduce the standard payment amount by 1.9 percent to account for coding changes.
- Revise the comorbidity tiers and CMGs.
- Use a weighted motor score index in assigning patients to CMGs.
- Update the relative weights.
- Update payments for rehabilitation facilities using a market basket reflecting the operating and capital cost structures for the RPL market basket.
- Provide the weights and proxies to use for the FY 2002-based RPL market basket.
- Indicate the methodology for the capital portion of the RPL market basket.
- Adopt the new geographic labor market area definitions as specified in §412.64(b)(1)(ii)(A)-(C).
- Use the New England MSAs as determined under the proposed new CBSA-based labor market area definitions.
- Implement a budget neutral 3 year hold harmless policy for FY 2005 rural IRFs redesignated as urban in FY 2006.
- Use FY 2001 acute care hospital wage data in computing the FY 2006 IRF PPS payment rates.
- Implement a teaching status adjustment.
- Update the formulas used to compute the rural and the LIP adjustments to IRF payments.

- Update the outlier threshold amount to maintain total estimated outlier payments at 3 percent of total estimated payments.
- Revise the methodology for computing the standard payment conversion factor (for FY 2006 only) to make the CMG and tier changes, the teaching status adjustment, and the updates to the rural and LIP adjustments in a budget neutral manner.

III. Analysis of and Responses to Public Comments

As stated above, we received approximately 55 timely items of correspondence containing multiple comments on the FY 2006 proposed rule (70 FR 30188) from providers, health industry organizations, the Medicare Payment Advisory Commission, and others. In general, commenters expressed some concerns about our proposals in light of other changes occurring in the IRF PPS at this time and suggested that we wait to implement the proposals until other recent IRF policy changes are fully implemented. However, many commenters supported the proposed changes to the facility-level adjustments. Summaries of the public comments received on the proposed provisions and our responses to those comments are provided in the appropriate sections of the preamble of this final rule.

IV. Research to Support Refinements of the Current IRF PPS

As described in the August 7, 2001 final rule, we

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

1. History of RAND's Research on the IRF PPS

In 1995, RAND began extensive research, sponsored by us, on the development of a per-discharge based PPS using a patient classification system known as Functional Independence Measures-Function Related Groups (FIM-FRGs) for IRFs. The results of RAND's earliest research, using 1994 data, were released in September 1997 and are contained in two reports available through the National Technical Information Service (NTIS). The reports are: Classification System for Inpatient Rehabilitation Patients-A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, NTIS order number PB98-105992INZ, and Prospective Payment System for Inpatient Rehabilitation, NTIS order number PB98-106024INZ.

In July 1999, we contracted with RAND to update its earlier research. The update included an analysis of Functional Independence Measure (FIM) data, the Function

Related Groups (FRGs), and the model rehabilitation PPS using 1996 and 1997 data. The purpose of updating the earlier research was to develop the underlying data necessary to support the Medicare IRF PPS based on CMGs for the November 3, 2000 proposed rule (65 FR at 66313). RAND expanded the scope of its earlier research to include the examination of several payment elements, such as comorbidities, facility-level adjustments, and implementation issues, including evaluation and monitoring.

Then, to develop the provisions of the August 7, 2001 final rule (66 FR 41316, 41323), RAND did similar analysis on calendar year 1998 and 1999 Medicare Provider Analysis and Review (MedPAR) files and patient assessment data.

We have continued to contract with RAND to help us identify potential refinements to the IRF PPS. The refinements we proposed to make to the IRF PPS, and which we are finalizing in this final rule, are based on the analyses and recommendations from RAND. In addition, RAND sought advice from a technical expert panel (TEP), which reviewed their methodology and findings.

2. Data Files Used for Analysis of the Current IRF PPS

RAND conducted updated analyses of the patient classification system, case mix and coding changes, and facility-level adjustments for the IRF PPS using data from calendar year 2002 and FY 2003. This is the first time CMS

or RAND has had data generated by IRFs after the implementation of the IRF PPS that are available for data analysis.

Public comments and our responses on RAND's research to support the proposed refinements are summarized below:

Comment: Several commenters expressed concerns about basing the refinements that we proposed in the FY 2006 proposed rule (70 FR 30188) on analyses of calendar year 2002 and FY 2003 data, which do not reflect IRF case mix changes currently taking place in response to our recent enforcement of the classification criterion, commonly known as the "75 percent rule." These commenters suggested that we wait for analysis of future data (CY 2005 or beyond) to become available before implementing refinements to the IRF PPS.

Response: As discussed in the August 7, 2001 final rule (66 FR 41316), we used RAND's analysis of calendar year 1998 and 1999 Medicare Provider Analysis and Review (MedPAR) files and patient assessment data to develop the initial classification system and prospective payment amounts for the IRF PPS. These data were from a period of time before the IRF PPS when IRFs' reimbursement was based on costs, subject to certain limits, rather than on prospective payment amounts. Furthermore, we used the best available 1998 and 1999 data from a time period that also preceded

enforcement of the 75 percent rule requirements. Today, we have 2002 and 2003 data that represents all Medicare-covered IRF cases in a post-PPS environment and, therefore, portrays a recent and complete picture of IRFs' patient populations.

In addition, the IRF payment system has undergone a major transformation since the 1998 and 1999 data in the form of a change from a cost-based payment system to a PPS that became effective with the cost reporting periods beginning on or after January 1, 2002. Because of this transformation, we believe the data we have on which to base refinements to the IRF PPS will help ensure that IRF PPS payments accurately reflect the costs of care in an IRF.

This is because these data allow RAND to obtain precision in their analyses, and ensures that the data are not over- or under- representing particular types of facilities or patients. We believe it is appropriate and necessary to implement refinements to the IRF PPS at this time, based on the best available data we have from calendar year 2002 and FY 2003. Since analysis of this data indicates that we have an opportunity at this time, through the proposed refinements, to improve the alignment between IRF payments and the cost of care, we believe it is important to proceed with the refinements discussed in this final rule.

However, we agree with the commenters that we should continue to collect the best available data we can to monitor the IRF PPS and ensure that IRF payments are appropriately aligned with costs of care and that Medicare patients continue to have appropriate access to IRF services. We will, whenever necessary, use the best data available in the future to propose appropriate refinements that will further improve the alignment between IRF payments and the costs of care. Thus, to the extent changes in case mix occur due to enforcement of the 75 percent rule, these changes should appear in later data that we will use to propose refinements in the future.

Comment: Several commenters noted that 98 IRF providers in RAND's analysis data affiliated with HealthSouth decided to omit home office cost data from the 2002 and 2003 cost reports that were filed with us. The commenters questioned whether this omission might have affected the results of RAND's analysis and, therefore, our proposed policies.

Response: After publication of the FY 2006 proposed rule (70 FR 30188), we learned that 98 providers in our data file that were affiliated with HealthSouth omitted home office cost data from the 2002 and 2003 cost reports that were filed with us and that RAND used in the analysis of the FY 2006 proposed rule (70 FR 30188). These data were a

voluntary omission on the part of these providers, but nevertheless affect some of the distributional policies (that is, the proposed teaching status adjustment, the proposed changes to the rural and LIP adjustments, and the proposed change to the outlier threshold) contained in the proposed rule. However, because RAND used the hospital-specific relative value method (that is, the methodology that effectively controls for inter-hospital variation while estimating the relative costs of different types of patients within each hospital) for all of the proposed changes to the classification system described in section V of this final rule (that is, the proposed changes to the tier comorbidities, the proposed changes to the CMG definitions, the proposed weighted motor score methodology, the proposed change to the coding of the transfer-to-toilet item, and the proposed update of the relative weights), these proposed changes would not have been affected by the omission of the home office cost data. In other words, RAND examined the relative costs of patients within each IRF, so the fact that the omission of HealthSouth's home office costs caused total costs to be understated in the cost report data would not have mattered for the proposed classification system changes described in section V of this final rule.

In addition, the omission of the home office cost data would have no effect on the proposed 1.9 percent reduction

to the standard payment amount (discussed in section VI.A of this final rule) because cost report data were not used in the analysis that supports this proposed reduction.

Although the omission of the home office cost data, in theory, could have had some effect on the estimates of the proposed FY 2002-based RPL market basket (discussed in section VI.B.1 of this final rule), our Office of the Actuary conducted some preliminary analyses of the effects on the market basket calculation and, based on these analyses, determined that these effects would likely be small. Home office costs represent only one of many cost categories (including, but not limited to, salaries, benefits, professional liability insurance, and pharmaceuticals) that are used to develop the cost category weights. We believe the absence of HealthSouth home office costs in this market basket has a minor impact on the distribution of these weights and, by extension, the final market basket update itself. Thus, we did not believe it was necessary to recalculate the market basket.

Finally, since the facility-level adjustments we proposed in the FY 2006 proposed rule (70 FR 30188) were calculated using regression analysis based on the relative total costs associated with care in different types of IRFs (that is, urban/rural, teaching/non-teaching, low DSH percentage/high DSH percentage), the omission of

HealthSouth's home office costs had some effect on the results of these analyses. The largest example is for the cost differential between urban and rural facilities in our analysis. Since the providers that omitted the home office cost data were largely urban facilities, their lower reported total cost data caused the differential between urban and rural facilities to be larger in the initial analyses. The same was true, to a lesser extent, with the teaching status adjustment and the LIP adjustment.

Furthermore, the omission of the home office cost data caused overall reported costs to be lower in these facilities and, therefore, affected the cost-to-charge ratios computed for these facilities for FYs 2002 and 2003.

We used these cost-to-charge ratios to determine the proposed update to the outlier threshold amount. Therefore, analysis of the data indicates that the outlier threshold amount we proposed in the FY 2006 proposed rule (70 FR 30188) was affected by the omission of the home office cost data.

Given that the facility-level adjustments, such as the rural, LIP, and teaching status adjustments, and the outlier threshold amount for all IRFs were likely affected by the decision of this one large for-profit chain provider to omit home office cost data from the FY 2002 and FY 2003 cost reports, we believe it is appropriate for us to recalculate

the values for these adjustments and for the outlier threshold using data that accounts for the omitted home office costs. Thus, we obtained the FY 2004 HealthSouth home office cost statement and, from this cost report statement, compiled the home office cost data for each of the individual HealthSouth IRF providers listed. Of the 98 providers that omitted home office cost data for FYs 2002 and 2003, 92 of the providers have had home office cost data reported on the FY 2004 home office cost statement; and six providers did not have any home office cost information for FY 2004.

We considered several options with respect to incorporating the missing HealthSouth home office costs into the data RAND used to conduct the analyses for this final rule. First, we considered the option of removing all of the HealthSouth cost report data from the analysis and re-computing the facility-level adjustments (that is, the rural adjustment, the LIP adjustment, and the teaching status adjustment) and the outlier threshold without the HealthSouth cost report data. Dropping all of the cost report data for 98 of the 1,188 facilities in RAND's analysis file, especially when they are large urban facilities, would seem to skew the data even further because we would be leaving out a substantial amount of cost report data connected with one specific type of IRF provider (i.e.,

urban IRFs). Leaving out the data for these facilities would make other types of IRFs that are left in the data appear to have more of an effect on the regression analysis than they actually do. Since we were hoping to reduce the bias in the data, rather than increase the bias, we generally rejected this option.

The second option we considered was to update the analysis using FY 2004 data for all providers and re-compute the facility-level adjustments and the outlier threshold using the FY 2004 cost report data. Unfortunately, the FY 2004 data have only recently been submitted by all IRF providers, and it would have been impossible for RAND and CMS to have completed all the necessary re-analysis of all of the proposed policies with the FY 2004 cost report data for all IRF providers in time for the proposed policies to be implemented in FY 2006.

The third option we considered was to use the FY 2004 home office cost data that we were able to obtain from the HealthSouth home office cost statement for 92 of the 98 HealthSouth IRF providers, standardize all of the other cost report data from FY 2003 for the 98 HealthSouth providers and the other non-HealthSouth providers using the most recent market basket for FY 2004, and fill in the FY 2004 home office cost data for the 92 HealthSouth providers for which we had data. This option enabled us to meet the

October 1 implementation date of our updates as well as to make those updates and payment adjustments as accurate as possible. Next, we considered two options for treating the six HealthSouth facilities for which we did not have FY 2004 home office cost data: We considered leaving those six IRFs' cost data as is, without adding any home office cost data since we had none from FY 2004 to add. The other option we considered for treating these six facilities was to take the average home office costs as a percentage of total costs for the 92 facilities (which came to approximately 13 percent) and use this as an estimate of home office costs for the 6 facilities. We chose the second of the two options, which meant that we inflated total costs for those six facilities by the average of about 13 percent, because it seemed inappropriate to ignore the fact that cost data was missing for these six facilities and 13 percent appeared to be a reasonable estimate of home office costs generally for IRFs (from the general analysis we were able to perform).

Because we believe the data file that results from the third option is more complete than the data RAND previously used to compute the proposed facility-level adjustments and the proposed outlier threshold amount for the FY 2006 proposed rule (70 FR 30188), we used the data from the third option described above to re-compute the values for the teaching status adjustment (described in more detail in

section VI.B.3 of this final rule), the rural adjustment (described in more detail in section VI.B.4 of this final rule), the LIP adjustment (described in more detail in section VI.B.5 of this final rule), and the outlier threshold amount (described in more detail in section VI.B.6 of this final rule). Because the values of these adjustments have changed, we also re-computed the budget neutrality factors and, thus, the standard payment conversion factor.

Comment: Several commenters requested that we make IRF claims data, IRF-PAI data, patient-specific CMG data, and cost report files available to the public so that the public would have the opportunity to recreate the analyses used in developing the proposed refinements for the FY 2006 proposed rule (70 FR 30188).

Response: The data files mentioned by the commenters are generally available (and were generally available during the comment period for the FY 2006 proposed rule (70 FR 30188)) to the public through CMS's standard data distribution systems. More information on CMS's data distribution policies is available on CMS's website at <http://www.cms.hhs.gov/researchers/statsdata.asp>.

Comment: A few commenters requested that we make available RAND's research using FY 2003 data. They noted that 3 of the 4 reports published on RAND's website for

public access are based on analysis of calendar year 2002 data. One of RAND's publicly available reports is based on analysis of FY 2003 data.

Response: We asked RAND to use the best available, most current data possible for the analyses contained in the FY 2006 proposed rule (70 FR 30188) and this final rule. This was generally FY 2003 data.

The updated analysis is generally not contained in RAND's reports, and RAND has indicated to CMS that they have no plans to publish the updated analyses (using the FY 2003 data) after publication of the final rule. However, RAND informed us that, in all of the FY 2003 analyses for the FY 2006 proposed rule (70 FR 30188) and for this final rule, they used the identical methodologies presented in the reports available on RAND's website and reviewed by RAND's technical expert panel. The only change was that RAND used updated data from FY 2003 (and FY 2004 HealthSouth home office cost data, as discussed above). Thus, interested parties should examine the reports available on RAND's website for the detailed methodology used to develop the proposed and final revisions. In addition, interested parties may contact RAND directly for more information regarding the analysis of FY 2003 data.

Comment: One commenter asked whether a large number of short period cost reports for periods ending in 2001 might

have affected RAND's research findings and, if so, how RAND handled this issue in the data.

Response: We were unable to find any reasons for the unusually large number of short period cost reports the commenter is indicating for cost report periods ending in 2001. However, since some of RAND's analysis for this final rule was based on calendar year 2002 data, and the majority of RAND's analysis for this final rule was based on FY 2003 data, we do not believe that a spike in the number of short period cost reports in 2001 would have had an effect on RAND's analyses.

V. Refinements to the Patient Classification System

A. Changes to the IRF Classification System

1. Development of the IRF Classification System

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

specific patients in IRFs within these groups as specified in §412.620.

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

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

We explained in the August 7, 2001 final rule that further analysis of FIM and Medicare data may result in refinements to CMGs. In the August 7, 2001 final rule, we used the most recent FIM and Medicare data available at that time (that is 1998 and 1999 data). Developing the CMGs with the 1998 and 1999 data resulted in 95 CMGs based on the FIM-FRG methodology. The data also supported the establishment of five additional special CMGs that improved the

explanatory power of the FIM-FRGs. We established one additional special CMG to account for very short stays and four additional special CMGs to account for cases where the patient expired. In addition, we established a payment of an additional amount for patients with at least one relevant comorbidity in certain CMGs.

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

a. Rehabilitation Impairment Categories

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

b. Functional Status Measures and Age

After using the RIC to define the first division among the inpatient rehabilitation groups, we used functional status measures and age to partition the cases further. In the August 7, 2001 final rule, we used 1998 and 1999 Medicare bills with corresponding FIM data to create the CMGs and more thoroughly examine each item of the motor and cognitive measures. Based on the data used for the

August 7, 2001 final rule, we found that we could improve upon the CMGs by making a slight modification to the motor measure. We modified the motor measure by removing the transfer to tub/shower item because we found that an increase in a patient's ability to perform functional tasks with less assistance for this item was associated with an increase in cost, whereas an increase in other functional items decreased costs. We describe below the statistical methodology (Classification and Regression Trees (CART)) that we used to incorporate a patient's functional status measures (modified motor score and cognitive score) and age into the construction of the CMGs in the August 7, 2001 final rule.

We used the CART methodology to divide the rehabilitation cases further within each RIC. (Further information regarding the CART methodology can be found in the seminal literature on CART (Classification and Regression Trees, Leo Breiman, Jerome Friedman, Richard Olshen, Charles Stone, Wadsworth Inc., Belmont CA, 1984: pp. 78-80).) We chose to use the CART method because it is useful in identifying statistical relationships among data and, using these relationships, constructing a predictive model for organizing and separating a large set of data into smaller, similar groups. Further, in constructing the CMGs, we analyzed the extent to which the independent variables

(motor score, cognitive score, and age) helped predict the value of the dependent variable (the log of the cost per case). The CART methodology creates the CMGs that classify patients with clinically distinct resource needs into groups. CART is an iterative process that creates initial groups of patients and then searches for ways to divide the initial groups to decrease the clinical and cost variances further and to increase the explanatory power of the CMGs. Our current CMGs are based on historical data. In order to develop a separate CMG, we need to have data on a sufficient number of cases to develop coherent groups. Therefore, we are removing these codes from the tiers that increase payment.

c. Comorbidities

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

of payment units for which payment is made under this title and other factors that may affect the relative use of resources. The adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

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

Furthermore, in the August 7, 2001 final rule, we indicated that comorbidities can affect cost per case for some of the CMGs, but not all. When comorbidities

substantially increased the average cost of the CMG and were determined to be clinically relevant (not inherent in the diagnosis in the RIC), we developed CMG relative weights adjusted for comorbidities (§412.620(b)).

d. Development of CMG Relative Weights

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

As indicated in the August 7, 2001 final rule, we

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

e. Overview of Development of the CMG Relative Weights

As indicated in the August 7, 2001 final rule, to calculate the relative weights, we estimate operating (routine and ancillary services) and capital costs of IRFs. For this final rule as we indicated in the FY 2006 proposed rule (70 FR 30188), we use the same method for calculating the cost of a case that we outlined in the August 7, 2001 final (66 FR at 41351 through 43153). We obtained cost-to-charge ratios for ancillary services and per diem costs for routine services from the most recent available cost report data. We then obtain charges from Medicare bill data and derived corresponding functional measures from the FIM data. We omit data from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, as well as from the parameters that we use to define transfer cases, because these facilities are paid a single, negotiated rate per discharge

and therefore do not maintain a charge structure. For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from cost reports. Our data analysis for the August 7, 2001 final rule showed that some departmental cost-to-charge ratios were missing or found to be outside a range of statistically valid values. For anesthesiology, a value greater than 10, or less than 0.01, is found not to be statistically valid. For all other cost centers, values greater than 10 or less than 0.5 are found not to be statistically valid. In the August 7, 2001 final rule, we replaced individual cost-to-charge ratios outside of these thresholds. The replacement value that we used for these aberrant cost-to-charge ratios was the mean value of the cost-to-charge ratio for the cost-center within the same type of hospital (either freestanding or unit). For routine services, per diem operating and capital costs are used to develop the relative weights. In addition, per diem operating and capital costs for special care services are used to develop the relative weights. (Special care services are furnished in intensive care units. We note that less than 1 percent of rehabilitation days are spent in intensive care units.) Per diem costs are obtained from each facility's Medicare cost report data. We use per diem

costs for routine and special care services because, unlike for ancillary services, we could not obtain cost-to-charge ratios for these services from the cost report data. To estimate the costs for routine and special care services included in developing the relative weights, we sum the product of routine cost per diem and Medicare inpatient days and the product of the special care per diem and the number of Medicare special care days.

In the August 7, 2001 final rule, we used a hospital specific relative value method to calculate relative weights. For the FY 2006 proposed rule (70 FR 30188) and this final rule, we used the following basic steps to calculate the relative weights as indicated in the August 7, 2001 final rule (at 66 FR 41316, 41351 through 41352).

The first step in calculating the CMG weights is to estimate the effect that comorbidities have on costs. The second step required us to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step were used to calculate "relative adjusted weights" in each CMG using the hospital-specific relative value method.

The final steps are to calculate the CMG relative weights by modifying the "relative adjusted weight" with the effects of the existence of the comorbidity tiers (explained below) and normalizing the weights to 1.

Our methodology for determining the IRF classification system remains unchanged from the August 7, 2001 final rule.

B. Changes to the Existing List of Tier Comorbidities

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

While our methodology for this final rule for determining the tiers remains unchanged from the August 7, 2001 final rule, as we indicated in the FY 2006 proposed rule (70 FR 30188), RAND's analysis indicates that 1.6 percent of FY 2003 cases received a tier payment (often in tier one) that was not justified by any higher cost for the case. Therefore, under statutory authority section 1886(j)(2)(C)(i) of the Act, as we proposed in the FY 2006 proposed rule (70 FR 30188) we are implementing several technical changes to the comorbidity tiers associated with the CMGs. Specifically, the RAND analysis found that the first 17 diagnoses shown in Table 1 below are no longer positively related to treatment cost after controlling for CMG. The additional two codes were also problematic. According to RAND, code 410.91 (AMI, NOS, Initial) was not specific enough to be differentiated from other related codes and code 260, Kwashiorkor, was found to be unrealistically represented in the data according to the RAND technical expert panel.

With respect to the eighteenth code in Table One, (410.X1) Specific AMI, initial), we note that RAND found there is no clinical reason to believe that this code differs in a rehabilitation environment from all of the specific codes for initial AMI of the form 410.X1, where X is an numeric digit. In other words, this code is indistinguishable from the seventeenth code in Table One (410.91 AMI, NOS, initial). Following this observation, RAND tested the other initial AMI codes as a single group and found that they have no positive effect on case cost. Thus, as we indicated in the FY 2006 proposed rule (70 FR 30188), we proposed to remove "AMI, NOS, initial" from the tier list because it is not positively related to treatment cost after controlling for the CMG. In addition, for similar reasons, we proposed in the FY 2006 proposed rule (70 FR 30188) to remove "Specific AMI, initial from the tier list since it is indistinguishable from "AMI, NOS, initial."

As we proposed in the FY 2006 proposed rule (70 FR 30188), with respect to the last code in Table One (Kwashiorkor), we are removing this code from the tier list as well. This comorbidity is positively related to cost in our data. However, RAND's technical expert panel (TEP) found the large number of cases coded with this rare disease to be unrealistic and recommended that it be removed from the tier list.

Table 1 contains two malnutrition codes, and as we proposed in the FY 2006 proposed rule (70 FR 30188), we are removing these two malnutrition codes. As we stated in the FY 2006 Proposed Rule (70 FR 30188), removal of these codes where use is concentrated in specific hospitals is particularly important because these hospitals are likely receiving unwarrantedly high payments due to the tier one assignment of these cases. Thus, because we believe the excess use of these two comorbid conditions is inappropriate based on the findings of RAND's TEP, they will be removed.

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

As we proposed in the FY 2006 proposed rule (70 FR 30188), we are finalizing changes to our initial list of diagnoses that deal with tracheostomy cases. These rare cases were

excluded from the pulmonary RIC 15 in the August 7, 2001 final rule. The new data indicate that they are more expensive than other cases in the same CMG in RIC 15, as well as in other RICs. Therefore, we believe the data demonstrate that tracheostomy cases should be added to the tier list for RIC 15 in order to receive a higher payment. Finally, the new data indicate that DX V55.0, "attention to tracheostomy" should be part of this condition as these cases were and are as expensive as other tracheostomy cases.

Thus, since "attention to tracheostomy" is as expensive as other tracheostomy cases, it is logical to group such similar cases together. Therefore, we are finalizing our proposal to remove the RIC 15 exclusion for code V55.0 (attention to tracheostomy) so that code V55.0 can receive appropriate payment for the additional costs it incurs.

As we stated in the FY 2006 proposed rule (70 FR 30188), we believe that the data provided by RAND support the removal of the codes in Table 1 below because they either have no impact on cost after controlling for their CMG or are indistinguishable from other codes or are unrealistically overrepresented. Therefore, we are finalizing our proposed policy to remove these codes from the tier list.

Table 1: List of Codes to be Removed From the Tier List

ICD-9-CM Code	Abbreviated Code Title	Condition
235.1	Unc behav neo oral/phar	Miscellaneous throat conditions
933.1	Foreign body in larynx	Miscellaneous throat conditions
934.1	Foreign body bronchus	Miscellaneous throat conditions
530.0	Achalasia & cardiospasm	Esophageal conditions
530.3	Esophageal stricture	Esophageal conditions
530.6	Acquired esophag diverticulum	Esophageal conditions
V46.1 *	Dependence on respirator	Ventilator status
799.4	Cachexia	Cachexia
V49.75	Status amputation below knee	Amputation of LE
V49.76	Status amputation above knee	Amputation of LE
V49.77	Status amputation hip	Amputation of LE
356.4	Idiopathic progressive polyneuropathy	Meningitis and encephalitis
250.90	Diabetes II, w unspecified complications, not stated as uncontrolled	Non-renal Complications of Diabetes
250.93	Diabetes I, w unspecified complications, uncontrolled	Non-renal Complications of Diabetes
261	Nutritional Marasmus	Malnutrition
262	Other severe protein calorie deficiency	Malnutrition
410.91	AMI, NOS, initial	Major comorbidities
410.X1	Specific AMI, initial	Major comorbidities
260	Kwashiorkor	Malnutrition

* V46.11 and V46.12 were not in existence when the data used in the analysis was collected. Since these codes are subcategories of code V46.1 (the code we proposed to remove from the tiers that make additional payment), they will be removed from the comorbidity tiers as well.

We received numerous comments on the proposed changes to the existing list of tier comorbidities which are summarized below:

Comment: One commenter remarked that kwashiorkor should be omitted from the list of comorbidities to be deleted from the list of comorbidities that increase the payment rate of the CMG because some of the software packages used by the industry allow this code to be used for the coding of the inpatient's comorbidities.

Response: We disagree with the commenter. Kwashiorkor is a severe malnutrition of infants and young children, primarily in tropical and subtropical regions, caused by deficiency in the quality and quantity of protein in the diet. It is characterized by anemia, edema, potbelly, loss of pigment in the skin, hair loss or change in hair color, hypoalbuminemia, and bulky stools containing undigested food. In addition, an inpatient with this condition most likely would not be able to receive the three hours of intensive rehabilitation that is a qualifying guideline to be an inpatient within an IRF. While protein deficiencies may be noted in patients within an IRF, by definition, the incidence of Kwashiorkor could not be as high as reported. Also, as previously stated, RAND's TEP reported that the data indicate large variation in the rate of increase across

conditions. However, coding of malnutrition increased by more than 10 times, and RAND found the large number of cases coded with this rare disease to be unrealistic and recommended that it be removed from the tier list.

Consequently, kwashiorkor will be eliminated from the list of comorbidities that increase the payment rate of the CMG.

Comment: One commenter wrote that code V46.1 is listed in the proposed list of codes to be removed from the tier list. Since this code contains two other codes, the commenter wanted to know if it is our intention to remove both codes in this category, namely V46.11 (Dependence on respirator, status) and V46.12 (Encounter for respirator dependence during power failure) or just one of these codes.

Response: First, we want to explain how codes V46.11 and V46.12 became codes that are used to increase the CMG payment rate. In the August 7, 2001 final rule (66 FR 41316), we published Appendix C that listed the ICD-9-CM comorbid condition codes which are used to increase the CMG payment rate. The ICD-9-CM codes of the comorbid conditions are recorded by the IRF's staff on the IRF-PAI, and that data as well as some other data recorded on the IRF-PAI is used to classify an inpatient into a CMG payment rate. One of the codes we published as part of Appendix C was V46.1. Each year the codes used in the ICD-9-CM coding system undergo a review resulting in updates to some of the

existing codes. In accordance with a review that updated the ICD-9-CM coding system V46.11 and V46.12 were added to the ICD-9-CM coding system as subcategories of V46.1. We believe that the comorbid condition represented by the code V46.11 or V46.12 is a derivative of the comorbid condition represented by the code V46.1. Therefore, in 2005 we updated the CMG grouper software which resulted in the CMG payment being increased by the same amount if the IRF-PAI data of an inpatient included codes V46.1, or V46.11, or V46.12.

The analysis that our data contractor performed, using certain data after the IRF PPS was implemented, shows that the comorbid condition represented by code V46.1 does not have an effect upon treatment cost after controlling for the CMG. Therefore, code V46.1 and its derivative codes that comprise it (V46.11 and V46.12) will be removed from the list of codes that are used by the IRF PPS to increase the CMG payment rate.

Comment: Several commenters urged us to consider not removing codes V49.75, V49.76, and V49.77 from the list of comorbidity codes that increase the CMG payment because of concerns with the complexity of a patient with an amputation.

Response: After controlling for the CMG, RAND found that these codes do not impact cost. Further, IRFs do not

incur additional costs to treat these comorbidities after controlling for the CMG. This means that the CMG to which the inpatient is assigned, already accounts for the costs associated with the treatment of inpatients with an amputation and no additional payment is needed beyond the CMG amount to adequately reimburse for such a case. Therefore we are removing these codes from the list of comorbidities that increase the CMG payment.

Comment: Several commenters mentioned a concern with the code V497.7 in the table of codes to be removed. They believed it to be a typographical error where the actual code to be removed is V49.77.

Response: We agree with the commenters and have made the correction to the typographical error. The corrected code to be removed is V49.77.

Comment: Several commenters noted that there is a discrepancy with code 428.3 (vocal cord paralysis, not otherwise specified) in CMS' list of codes being reassigned based on their marginal cost in the Comorbidity Tier Reassignment Changes File found at <http://www.cms.hhs.gov/providers/irfpps/fy06nprm.asp> . They stated that it should actually be code 478.30 (vocal cord paralysis, not otherwise specified).

Response: We agree with the commenters and shall make the appropriate corrections to the typographical error

within the file.

Comment: Several commenters noted an error with the description of meningitis and encephalitis for code 356.4 in the Comorbidity Tier Reassignment Changes File found at <http://www.cms.hhs.gov/providers/irfpps/fy06nprm.asp> .

Response: We agree with the commenters and the description will be amended to read idiopathic progressive polyneuropathy for code 356.4.

Comment: Commenters expressed concern for the removal of codes 530.0 (achalasia and cardiospasm) , 530.3 (stricture and stenosis of esophagus) and 530.6 (diverticulum of esophagus) that are used to record esophageal conditions because of costs associated with these conditions and requested that they not be removed from the tier list which increases payment for these comorbidities.

Response: After controlling for the CMG, RAND found that these comorbidities do not positively impact costs, meaning that the CMG encompasses sufficient payment to compensate for these comorbidities. Therefore, we are removing codes 530.0, 530.3 and 530.6 from the list of comorbidities that increase CMG payment.

Comment: Several commenters agreed with CMS' proposed policy to remove malnutrition codes 261 (nutritional marasmus) and 262 (other severe protein-calorie malnutrition), while others opposed the proposed policy to

remove these codes. In addition, several commenters suggested that CMS examine the impact of malnutrition on increasing the length of stay within an IRF.

Response: We acknowledge both opinions as expressed by the different commenters. The RAND TEP, and our Medical Officers, believes these codes are drastically overstated and inpatients with these levels of malnutrition would not be candidates for three hours of intensive therapy. In addition, after controlling for the CMG, both of these codes do not positively affect payment. Therefore we believe it is appropriate to remove malnutrition codes 261 and 262 from the list of comorbidity codes that are used to increase the CMG payment rate. Additionally, we will continue to examine the impact of comorbidities, including malnutrition, upon IRF Medicare-covered inpatients.

Comment: One commenter suggested adding codes 250.91 and 250.92 to the list of comorbidities to be removed from the list of codes used to increase payment because they believe those codes to be similar in description to codes 250.90 and 250.93.

Response: Only the first 17 codes within Table 1 were found to have no positive effect on cost after controlling for the CMG. The data analysis performed by RAND does not indicate that at this time 250.91 and 250.93 should be removed from the list of codes used to increase the CMG

payment rate because they continue to positively affect costs. Therefore we believe it is inappropriate to remove them from the list of comorbidities that impact cost. Consequently, we are not removing any other codes from the list of codes used to increase the CMG payment rate.

Comment: One commenter recommended that several codes be added to our comorbidity tier system based upon suggestions from the RAND TEP, namely codes 428.0 (congestive heart failure), V43.3 (heart valve replacement), 250.1 (insulin dependent diabetes without mention of complications, not stated as controlled) and 438.2X (hemi-paresis due to an old stroke).

Response: After examining the RAND recommendations, our Medical Officers felt that codes V43.3 and 438.2X were too vague and non-descript to capture the necessary information needed for these codes to be added to the list of codes used to increase the CMG payment rate. However, in response to the comments our Medical Officers re-evaluated the effect on cost by the comorbid condition represented by code 250.1 (insulin dependent diabetes without mention of complications, not stated as controlled). They determined that code 250.1 should be added to the list of codes used to increase the CMG payment rate. They also determined that the code should be a tier 3 code because the other 250 series of codes related to diabetes are in tier 3. Therefore, this

code will be added as a tier 3 code to the list of codes used to increase the CMG payment rate. There will be no excluded RICs with code 250.1. After examining the comments, our Medical Officers continue to believe that 428.9 (heart failure, unspecified), was too non-descript and should not be added to the list of codes that can increase payment. However, our Medical Officers agree with the commenter regarding other numerous congestive heart failure codes including Code 428.1-Left Heart Failure, Code 428.20-Systolic Heart Failure Unspecified, Code 428.21-Systolic Heart Failure Acute, Code 428.22-Systolic Heart Failure Chronic, Code 428.23-Systolic Heart Failure Acute on Chronic, Code 428.30-Diastolic Heart Failure Unspecified, Code 428.31-Diastolic Heart Failure Acute, Code 428.32-Diastolic Heart Failure Chronic, Code 428.33-Diastolic Heart Failure Acute on Chronic, Code 428.40-Combined Systolic and Diastolic Heart Failure Unspecified, Code 428.41-Combined Systolic and Diastolic Heart Failure Acute, Code 428.42-Combined Systolic and Diastolic Heart Failure Chronic, and Code 428.43-Combined Systolic and Diastolic Heart Failure Acute on Chronic, largely due to the increased costs associated with these codes. Therefore, these 428 cardiac codes will be added to the list of codes used to increase the CMG payment rate as tier 3 codes because of their similarity to certain cardiac codes with respect to resource

utilization. However, these codes will not be used to increase the CMG payment rate if the CMG code is one of the CMG codes derived from RIC 14 (the cardiac RIC) because these cardiac codes costs have been accounted for in the CMGs associated with RIC 14.

Comment: A commenter believes that the CMG payment rate should include an adjustment for mental health problems, such as a depression. The commenter believes that a patient's mental health status has an effect on the patient treatment costs an IRF incurs.

Response: The significance and appropriateness of a patient's state of mental health in response to an impairment that requires a patient to undergo intensive inpatient rehabilitation is a subject that we believe requires further study. Additional study will help to determine the effect of the patient's state of mental health on treatment costs. An ICD-9-CM code may be used to show that a patient is exhibiting signs that a rehabilitation clinician believes indicate a mental disorder. However, quantifying by use of ICD-9-CM codes the association between a patient's state of mental health and how it affects a patient's response to rehabilitation treatment is at best limited. For example, we believe that in response to a stroke or hip fracture, or some other impairment, a situational depression may be a rational response. However,

that does not mean that the IRF will incur additional costs that were not already taken into account when the CMG payment rates were developed. In addition, mental disorders vary greatly in severity as does how a patient's functioning is affected by a mental disorder.

There would have to be multiple factors taken into consideration before any type of mental disorder could be added to the list of comorbidities that would increase payment of the CMG. The data for a complete psychiatric evaluation must be made available to correctly code for these comorbidities. In addition, this is a budget neutral system, and no additional funding will be added to the system. Under our final rule, funds will not be added but simply be redistributed among the comorbidities among the tiers that increase payment. This is because the changes associated with the comorbidity tiers and CMGs are done in a budget neutral manner. On the assumption that there is an even distribution of these psychiatric patients among IRFs, and these patients may receive the redistributed payment, the addition of these codes may not contribute to an increased payment for inpatients with these comorbid conditions and may affectively lower payments for CMG's with other comorbid conditions because the same amount of funding is distributed across more comorbid conditions. Also, few IRFs have psychiatric personnel and rehabilitation doctors

rarely have the time required to observe the patient to make a complete psychiatric evaluation and thus some codes may be assigned (or not assigned) in error. In addition, RAND's TEP believed that it would be inappropriate to use ICD-9-CM diagnoses to identify patients with affective disorders. Therefore, in this final rule, we are not adding codes for depression and mental disorders to the list of codes used to increase payment.

Comment: We received comments to both challenge and support the removal of certain comorbidity codes from the tier list including code 799.4 Cachexia, and code 933.1 (foreign body in larynx). Commenters stated that these conditions required more resources, and thus increased treatment costs. The other commenter stated that the CMG already covered these costs.

Response: The data analysis did not show that the comorbid conditions indicated by these codes increased the costs of treating an inpatient with these comorbidities after controlling for the CMG because their CMG payment rate covers costs associated with their corresponding treatment.

The more recent RAND analysis found that after controlling for the CMG, these comorbidities do not impact cost. Therefore, we are removing them from the comorbidity tiers that would increase payment.

Comment: One commenter made a general statement stating

that the list of comorbidities that comprise the tiers do not reflect the challenges that contribute to higher costs in the rehabilitation setting.

Response: We disagree with the commenter because the RAND regression analyses show that the comorbid conditions that comprise the tiers positively impact cost and provide additional payments for services not included in the payment associated with the CMG.

Final Decision: In this final rule, we are adopting the proposal to remove the comorbidity tier codes set forth in Table 1 of the FY 2006 proposed rule (70 FR 30188). We are also removing codes V46.11 and V46.12 because they are subcategories of code V46.1, which has been found to have no impact on cost after controlling for the CMG. We are adding several codes that the RAND analyses found to positively impact costs. We chose to add codes 250.1 (insulin dependent diabetes without mention of complications, not stated as controlled), as well as numerous congestive heart failure codes including Code 428.1-Left Heart Failure, Code 428.20-Systolic Heart Failure Unspecified, Code 428.21-Systolic Heart Failure Acute, Code 428.22-Systolic Heart Failure Chronic, Code 428.23-Systolic Heart Failure Acute on Chronic, Code 428.30-Diastolic Heart Failure Unspecified, Code 428.31-Diastolic Heart Failure Acute, Code 428.32-Diastolic Heart Failure Chronic, Code 428.33-Diastolic Heart

Failure Acute on Chronic, Code 428.40-Combined Systolic and Diastolic Heart Failure Unspecified, Code 428.41-Combined Systolic and Diastolic Heart Failure Acute, Code 428.42-Combined Systolic and Diastolic Heart Failure Chronic, and Code 428.43-Combined Systolic and Diastolic Heart Failure Acute on Chronic, which our Medical Officers believe were specific enough to be used in our list of codes that are used to increase the CMG payment amount.

2. Changes to Move Dialysis to Tier One

As we proposed in the FY 2006 proposed rule (70 FR 30188), we are finalizing the movement of dialysis from comorbidity tier two to comorbidity tier one, which is the tier associated with the highest payment. The data from the RAND analysis show that patients on dialysis cost more than the tier payment to which dialysis is currently assigned, and should be moved into the highest paid tier because this tier would more closely align payment with the cost of a case. Based on RAND's analysis using 2003 data, a patient with dialysis costs 31 percent more than a non-dialysis patient in the same CMG and with the same other accompanying comorbidities.

Overall, the largest increase in the cost of a condition occurs among patients on dialysis, where the coefficient in the cost regression increases by 93 percent, from 0.1400 to 0.2697. Part of the explanation for the

increased coefficient could be that some IRFs had not borne all dialysis costs for their patients in the pre-PPS period, which was the previous data analysis time period (because providers were previously permitted to bill for dialysis separately). It is likely that, in the 1999 data, some IRFs had not borne all dialysis costs for their patients. Because the fraction of cases coded with dialysis increased by 170 percent, it is also likely that improved coding was part of the explanation for the increased coefficient. We believe a 170 percent increase is such a dramatic increase that it would be highly unlikely that in the time periods used for the data analysis, 170 percent more patients needed dialysis when compared to the time period before the implementation of the IRF PPS. We also believe that the improved coding is likely due to the fact that higher costs are associated with dialysis patients, and therefore IRFs, in an effort to ensure that their payments cover these higher expenses better and more carefully coded comorbidities whose presence resulted in higher PPS payments.

Therefore we are moving dialysis patients to comorbidity tier one will more adequately compensate IRFs for the extra cost of those patients and thereby maintain or increase access to these services.

Comment: A number of commenters supported our decision to move dialysis patients to tier one due to the increase cost of dialysis patients.

Response: We agree with these commenters. The data analyses performed by RAND found evidence that suggested that a dialysis patient cost 31 percent more than a non-dialysis patient in the same CMG. Therefore, as proposed in the FY 2006 proposed rule (70 FR 30188), we are moving dialysis to tier 1 because the additional payment associated with tier 1 more closely approximate the additional costs associated with the treatment of an inpatient with this condition.

Final Decision: As proposed in the FY 2006 proposed rule (70 FR 30188), we are adopting the decision to move dialysis patients to comorbidity tier one.

3. Changes to Move Comorbidity Codes Based on Their Marginal Cost

Under section 1886(j) (2) (C) (i) of the Act, as was proposed in the FY 2006 proposed rule (70 FR 30188), we are refining how we pay for a comorbidity based on marginal cost. A commonly understood definition of marginal cost is

the increase or decrease in costs as a result of one higher or lower unit of a good or service. In this situation, we are reassigning comorbidities to tiers based on their marginal costs, and by this we mean the increase or decrease in costs as a result of one higher or lower comorbidity tier. Payment for several comorbidities would be more accurate if their tier assignments were changed, and after examining RAND's data, we believe that of the FY 2003 cases, a full 4 percent of cases should be associated with comorbidity tiers that have a lower payment than the comorbidity tiers to which they were assigned. Therefore, comorbidities would be more accurate if their tier assignments were more appropriately based on their marginal costs.

As we proposed in the FY 2006 proposed rule (70 FR 30188), comorbidity tier assignments in this final rule are based on the results of statistical analyses RAND has performed under contract with CMS, using as independent variables only the CMGs and conditions for tiers. As we proposed in the FY 2006 proposed rule (70 FR 30188), tier assignments of each of these conditions for the final rule are determined based on the magnitude of their coefficients in RAND's statistical analysis.

We believe the IRF PPS led to substantial changes in coding of comorbidities between 1999 (pre-implementation of

the IRF PPS) and 2003 (post-implementation of the IRF PPS).

The percentage of cases with one or more comorbidities increased from 16.79 percent according to the data used to define the comorbidity tiers (1998 through 1999) to 25.51 percent in FY 2003. This is an increase of 52 percent in tier incidence ($52 = 100 \times (25.51 - 16.79) / 16.79$). The recording of a tier one comorbidity, the highest paid of the tiers, almost quadrupled during this same time period. Although, improved coding likely increased the recording of comorbidities, those coding the comorbidities may have been motivated by the objective to use coding changes as a means to increase the CMG payment.

The 2003 data provides an excellent comprehensive picture of the costs that are associated with each of the comorbidities. We believe this because CMS has data for 100 percent of the Medicare-covered IRF cases. Therefore, as we indicated in the FY 2006 proposed rule, we believe that using the 2003 data to assign the comorbidities to a payment tier ensures heightened accuracy with respect to the matching of payments to relative costs of a case.

We received several comments on the proposed changes to the existing list identifying which tier is associated with a particular comorbidity. The public comments are summarized below.

Comment: One commenter suggested that we postpone reassigning comorbidity tiers based on their marginal costs, and again instead perform the data analysis used to reassign the comorbidity codes based on marginal costs using more current data.

Response: This final rule reflects the most recent analysis of data. In the future, we will continue to perform data analyses and, as necessary, adjust the payment rates to achieve the most accurate payment. In this final rule, we are adopting the policy we proposed in the FY 2006 proposed rule (70 FR 30188), and reassigning comorbidities to tiers based on their marginal cost because we believe that this reassignment is based on the best comprehensive post-PPS implementation data that are available at this time.

Comment: One commenter recommended that we not reassign any comorbidity codes based on their marginal costs under the premise that there is no concrete evidence of upcoding.

Response: Taking into consideration that we believe that there has been improved coding due to prospective payment based system, the recommendations of RAND's

technical expert panel, and the guidance of our Medical Officers, we believe that the comorbidity codes should be assigned based on their marginal costs in order to increase the association between costs and payment.

Final Decision: In summary, we are adopting all of the proposals set forth in the FY 2006 proposed rule (70 FR 30188), with regard to the removal of the list of codes from comorbidity tiers that increase payment, the movement of dialysis patients to tier one, the code V55.0 will no longer be excluded from RIC 15, and comorbidity codes will now be reassigned based on their marginal costs.

C. Changes to the CMGs

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

In the FY 2006 proposed rule (70 FR 30188, 30196), in accordance with section 1886(j)(2)(C)(i) of the Act and as specified in §412.620(c) and based on the research conducted

by RAND, we proposed to update the CMGs used to classify IRF patients for purposes of establishing payment amounts. We also proposed to update the relative weights associated with the payment groups based on FY 2003 Medicare bill and patient assessment data. We proposed replacing the current unweighted motor score index used to assign patients to CMGs with a weighted motor score index that would improve our ability to accurately predict the costs of caring for IRF patients, as described in detail below. However, we proposed not to change the methodology for computing the cognitive score index.

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

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

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

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

Using the inpatient rehabilitation facility assessment instrument before the PPS, which is commonly referred to as the FIM, and Medicare data from 1998 and 1999, RAND helped us develop the original structure of the IRF PPS. IRFs became subject to the PPS beginning with cost reporting periods starting on or after January 1, 2002. The PPS is

based on assigning patients to particular CMGs that are designed to predict the costs of treating particular Medicare patients according to how well they function in four general categories: transfers, sphincter control, self-care (for example, grooming, eating), and locomotion. Patient functioning is measured according to 18 categories of activity: 13 motor tasks, such as putting on clothing, and 5 cognitive tasks, such as memory. The PPS is intended to align payments to IRFs as closely as possible with the actual costs of treating patients. If the PPS "underpays" for some kinds of care, IRFs have incentives to limit access for patients requiring that kind of care because payments for a particular case would be less than the costs of providing care, so an IRF may try to limit its financial "losses"; conversely, if the PPS overpays, resources are wasted because IRFs' payments exceed the costs of providing care for a particular case.

The fiscal year 2003 data file currently available for refining the CMGs contains many more IRF cases and represents the universe of Medicare-covered IRF cases, rather than a sample. The best available data that CMS and RAND had for analysis in 1999 contained 390,048 IRF cases, representing 64 percent of all Medicare-covered patients in participating IRFs. The more recent data contain 523,338 IRF cases (fiscal year 2003), representing all Medicare-

covered patients in participating IRFs. The larger file enables RAND to obtain greater precision in the analysis and portrays a more recent and complete picture of patients under the IRF PPS.

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

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

1. Changes for Updating the CMGs

In the FY 2006 proposed rule (70 FR 30188), we proposed

to revise the definitions of the CMGs based on regression analysis by RAND of the FY 2003 data. As described in the August 7, 2001 final rule, RAND developed the original list of CMGs using FIM data from 1998 and 1999 (see the FY 2006 proposed rule (70 FR 30188, 30198 through 30202) for a table of the original CMG listing).

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

As we explained in the FY 2006 proposed rule (70 FR 30188), RAND's analysis of the FY 2003 data, along with the support and guidance of the TEP, strongly suggested the need to update the CMGs to better align payments with costs under the IRF PPS. The other option we considered before proposing to update the CMGs with the fiscal year 2003 data was to maintain the same CMG structure but

recalculate the relative weights for the current CMGs using the 2003 data. After carefully reviewing the results of RAND's regression analysis, which compared the predictive ability of the CMGs under 3 scenarios (not updating the CMGs or the relative weights, updating only the relative weights and not the CMGs, and updating both the relative weights and the CMGs), as we stated in the FY 2006 proposed rule (70 FR 30188), we believed and continue to believe (based on RAND's analysis) that updating both the relative weights and the CMGs will allow the classification system to do a better job of reflecting changes in treatment patterns, technology, case mix, and other factors which may affect the relative use of resources.

We continue to believe it is appropriate to update both the CMGs and the relative weights at this time because the 2003 data we now have represent a more recent and broader set of data elements. The more recent data include all Medicare-covered IRF cases rather than a subset, allowing us to base the CMG changes on a complete picture of the types of patients in IRFs. In designing the IRF PPS, we used the best available data, but those data may not have contained a complete picture of the types of patients in IRFs. Also, the improved clinical coding of patient conditions in IRFs is better reflected in the more recent data than it was in the best available data we had to design the IRF PPS. In

addition, changes in treatment patterns, technology, case mix, and other factors affecting the relative use of resources in IRFs since the IRF PPS was implemented likely require an update to the classification system.

Prior to the finalization of the proposed changes contained in this final rule, we paid IRFs based on 95 CMGs and 5 special CMGs developed using the CART algorithm applied to 1999 data. The CART algorithm that was used in designing the IRF PPS assigned patients to RICs according to their age and their motor and cognitive FIM scores. CART produced the partitions so that the reported wage-adjusted rehabilitation cost of the patients was relatively constant within partitions. Then, a subjective decision-making process was used to decrease the number of CMGs (to ensure that the payment system did not become unduly complicated), to enforce certain constraints on the CMGs (to ensure that, for instance, IRFs were not paid more for patients who had fewer comorbidities than for patients with more comorbidities), and to fit the comorbidity tiers. Although the use of a subjective decision-making process (rather than a computer algorithm) was very useful, there were limitations. For example, it made it difficult to explore the implications of variations to the CART models because an individual person is not able to examine as many variations of a model in as short a period of time as a computer

program. Furthermore, the computer is more efficient at accounting for all of the possible combinations and interactions between important variables that affect patient costs.

In analyzing potential refinements to the IRF PPS, RAND created a new algorithm that would be very useful in constructing the CMGs (the new algorithm would be based on the CART methodology described in detail in section V.A.2.b of this final rule). RAND applied the new algorithm to the fiscal year 2003 IRF data. In the FY 2006 proposed rule (70 FR 30188), we proposed to use RAND's new algorithm for refinements to the CMGs. The algorithm is based entirely on an iterative computerized process to decrease the number of CMGs, enforce constraints on the CMGs, and assign the comorbidity tiers. At each step in the process, the new CART algorithm produces all of the possible combinations of CMGs using all available variables. It then selects the variables and the CMG constructions that offer the best predictive ability, as measured by the greatest decrease in the mean-squared error. We proposed to place the following constraints on the algorithm, based on RAND's analysis:

- (1) neighboring CMGs would have to differ by at least \$1,500, unless eliminating the CMG would change the estimated costs of patients in that CMG by more than \$1,000;
- (2) estimated costs for patients with lower motor or

cognitive index scores (more functionally dependent) would always have to be higher than estimated costs for patients with higher motor or cognitive index scores (less functionally dependent). We believe that the PPS should not pay more for a patient who is less functionally dependent than for one who is more functionally dependent; and (3) each CMG must contain at least 50 observations (for statistical validity).

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

The following are the most substantial differences between the CMGs used prior to October 1, 2005 and the proposed new CMGs for FY 2006:

- Fewer CMGs than before (87 now compared with 95 in the prior system). The 5 special CMGs for very short stay cases and cases in which the patient expires would remain unchanged.
- The number of CMGs under the RIC for stroke patients (RIC 1) would decrease from 14 to 10.

- The cognitive index score would affect patient classification in two of the RICs (RICs 1 and 2), whereas it previously affected RICs 1, 2, 5, 8, 12, and 18.

- A patient's age would now affect assignment for CMGs in RICs 1, 4 and 8, whereas it previously affected assignment for CMGs in RICs 1 and 4.

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

Public comments and our responses on the proposed changes for updating the CMGs are summarized below.

Comment: Several commenters raised concerns that the FY 2003 data used to update the CMGs did not reflect the full enforcement of the 75 percent rule and that CMS should, therefore, wait until the data reflect full enforcement before making any changes to the CMGs.

Response: We agree that additional changes to the CMGs may potentially be necessary in the future if enforcement of the 75 percent rule results in substantial changes to IRFs' patient populations. However, we believe it is now appropriate to begin refining the system because several

recent developments make significant improvements in the alignment between Medicare payments and actual IRF costs possible. First, when the IRF PPS was implemented for cost reporting periods beginning on or after January 1, 2002, a new recording instrument called the IRF-PAI was used to collect patient data. The new instrument contained questions that improved the quality of the patient-level information available to researchers. The 2003 data used in the proposed refinements reflects this data.

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

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

We further note that making refinements to the IRF patient classification system now, based on post-PPS data, does not preclude us from making future refinements to the system if IRFs' case mix and care practices change over time. We will continue to monitor the IRF PPS, and make refinements as needed, to ensure that IRF payments are

aligned as closely as possible with the costs of providing care.

Comment: One commenter believed that the proposed changes to the CMGs would make IRF quality measurement more difficult over time because the proposed changes to the CMG definitions would mean that a case classified into a particular CMG (such as CMG 0107) before October 1, 2005 (when the proposed changes would be implemented) would not necessarily be classified into CMG 0107 after October 1, 2005. Thus, people attempting to create a one-for-one crosswalk between the CMGs before October 1, 2005 and the proposed CMGs after October 1, 2005 would be unable to do so. The commenter noted that many quality measurement tools currently being used by IRFs require such a one-for-one crosswalk.

Response: We recognize the importance of monitoring IRF quality of care over time. However, we do not believe that the proposed changes to the CMGs inhibit the ability to monitor quality in IRFs over time. Quality of care is not measured by a payment rate, but by data reflecting various indicators of the treatment patients receive. In the FY 2006 proposed rule (70 FR 30188), we did not propose changes to the patient assessment form itself or changes to the coding of the underlying data that is used to classify patients into CMGs. Therefore, comparisons of the underlying patient classification data could still be used to monitor quality in these facilities over time.

Comment: One commenter expressed concerns that the cognitive scores are not used as often in the definitions of the proposed revisions to the CMGs as they were in the original CMGs defined in the August 7, 2001 final rule. This commenter stated that the cognitive scores are important predictors of how costly patients are likely to be in the IRF setting. The commenter also stated that, if cognitive scores are not used as often as motor scores for assigning patients to CMGs, the reason may be that measures of patients' cognitive abilities may not currently be as well developed as measures of patients' motor abilities. Therefore, this commenter recommended that we develop more sensitive measures that have better predictive qualities.

Response: As we noted previously, the cognitive score used to classify IRF patients into CMGs is made up of cognitive items from the IRF-PAI. These cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. Patients' cognitive functioning clearly affects their expected costliness in an IRF. However, RAND's regression analysis, in which they explored the relationship of the FIM motor and cognitive scores to cost, showed that patients' cognitive scores generally did not predict patients' expected costliness above and beyond what patients' motor scores already were able to predict. Thus, we see no reason to use

cognitive scores in CMG definitions for which they do not add predictive ability. When the cognitive scores add information that increases the predictive ability of the classification system, we make use of this information in the CMG assignment.

We agree with one of the commenter's points that the cognitive score may not predict costs as well as the motor score because the cognitive items may not be as sensitive to patients' cognitive status as the motor items are to patients' physical functioning. We further agree with the commenter that more work could be done to better identify measures of cognitive functioning. Along these lines, CMS has awarded a contract to the Research Triangle Institute (RTI) to perform research and data analysis to support possible changes to the IRF-PAI instrument that would better capture physical and cognitive functioning information on IRF patients. CMS remains open to examining well-constructed peer-reviewed studies by other types of providers, researchers, and other interested parties in order to improve upon the cognitive assessment functioning measures for the Medicare population. Until then, we will use the best cognitive functioning information available for IRF patients to classify patients into the most appropriate CMGs so IRF payments align as closely as possible with the costs of care in IRFs.

Final Decision: After carefully considering all the comments we received on the proposed changes to the CMG

definitions, we are finalizing our decision to adopt the CMG definitions presented below in Table 2. Based on RAND's regression analysis of FY 2003 data, the best data available for analysis, we believe these changes will increase the accuracy of IRF PPS payments.

Table 2—Case Mix Groups (CMGs), With the Associated Rehabilitation Impairment Categories (RICs), beginning with discharges on or after October 1, 2005.

<i>RIC</i>	<i>CMG Number</i>	<i>CMG Description</i>
01 Stroke (Stroke)	0101	Motor >51.05
	0102	Motor >44.45 & Motor <51.05 & Cognitive >18.5
	0103	Motor >44.45 & Motor <51.05 & Cognitive <18.5
01 Stroke (Stroke)	0104	Motor >38.85 & Motor <44.45
	0105	Motor >34.25 & Motor <38.85
	0106	Motor >30.05 & Motor <34.25
	0107	Motor >26.15 & Motor <30.05
	0108	Motor <26.15 & Age >84.5
	0109	Motor >22.35 & Motor <26.15 & Age <84.5
	0110	Motor <22.35 & Age <84.5
02 Traumatic brain injury (TBI)	0201	Motor >53.35 & Cognitive >23.5
	0202	Motor >44.25 & Motor <53.35 & Cognitive >23.5
	0203	Motor >44.25 & Cognitive <23.5

<i>RIC</i>	<i>CMG Number</i>	<i>CMG Description</i>
	0204	Motor >40.65 & Motor <44.25
	0205	Motor >28.75 & Motor <40.65
	0206	Motor >22.05 & Motor <28.75
	0207	Motor <22.05
03 Nontraumatic brain injury (NTBI)	0301	Motor >41.05
	0302	Motor >35.05 & Motor <41.05
	0303	Motor >26.15 & Motor <35.05
	0304	Motor <26.15
04 Traumatic spinal cord injury (TSCI)	0401	Motor >48.45
	0402	Motor >30.35 & Motor <48.45
	0403	Motor >16.05 & Motor <30.35
	0404	Motor <16.05 & Age >63.5
	0405	Motor <16.05 & Age <63.5
05 Nontraumatic spinal cord injury (NTSCI)	0501	Motor >51.35
05 Nontraumatic spinal cord injury (NTSCI)	0502	Motor >40.15 & Motor <51.35
	0503	Motor >31.25 & Motor <40.15
	0504	Motor >29.25 & Motor <31.25
	0505	Motor >23.75 & Motor <29.25
	0506	Motor <23.75
06 Neurological (Neuro)	0601	Motor >47.75
	0602	Motor >37.35 & Motor <47.75
	0603	Motor >25.85 & Motor <37.35
	0604	Motor <25.85
07 Fracture of LE (FracLE)	0701	Motor >42.15
	0702	Motor >34.15 & Motor <42.15
	0703	Motor >28.15 & Motor <34.15

<i>RIC</i>	<i>CMG Number</i>	<i>CMG Description</i>
	0704	Motor <28.15
08 Replacement of LE joint (RepLE)	0801	Motor >49.55
	0802	Motor >37.05 & Motor <49.55
	0803	Motor >28.65 & Motor <37.05 & Age >83.5
	0804	Motor >28.65 & Motor <37.05 & Age <83.5
	0805	Motor >22.05 & Motor <28.65
	0806	Motor <22.05
	09 Other orthopedic (Ortho)	0901
0902		Motor >34.35 & Motor <44.75
0903		Motor >24.15 & Motor <34.35
0904		Motor <24.15
10 Amputation, lower extremity (AMPLE)	1001	Motor >47.65
	1002	Motor >36.25 & Motor <47.65
	1003	Motor <36.25
11 Amputation, other (AMP-NLE)	1101	Motor >36.35
11 Amputation, other (AMP-NLE)	1102	Motor <36.35
12 Osteoarthritis (OsteoA)	1201	Motor >37.65
	1202	Motor >30.75 & Motor <37.65
	1203	Motor <30.75
13 Rheumatoid, other arthritis (RheumA)	1301	Motor >36.35
	1302	Motor >26.15 & Motor <36.35
	1303	Motor <26.15
14 Cardiac (Cardiac)	1401	Motor >48.85
	1402	Motor >38.55 & Motor <48.85
	1403	Motor >31.15 & Motor <38.55
	1404	Motor <31.15
15 Pulmonary (Pulmonary)	1501	Motor >49.25

<i>RIC</i>	<i>CMG Number</i>	<i>CMG Description</i>
	1502	Motor >39.05 & Motor <49.25
	1503	Motor >29.15 & Motor <39.05
	1504	Motor <29.15
16 Pain Syndrome (Pain)	1601	Motor >37.15
	1602	Motor >26.75 & Motor <37.15
	1603	Motor <26.75
17 Major multiple trauma, no brain injury or spinal cord injury (MMT-NBSCI)	1701	Motor >39.25
	1702	Motor >31.05 & Motor <39.25
	1703	Motor >25.55 & Motor <31.05
	1704	Motor <25.55
18 Major multiple trauma, with brain or spinal cord injury (MMT-BSCI)	1801	Motor >40.85
	1802	Motor >23.05 & Motor <40.85
	1803	Motor <23.05
19 Guillian Barre (GB)	1901	Motor >35.95
19 Guillian Barre (GB)	1902	Motor >18.05 & Motor <35.95
	1903	Motor <18.05
20 Miscellaneous (Misc)	2001	Motor >49.15
	2002	Motor >38.75 & Motor <49.15
	2003	Motor >27.85 & Motor <38.75
	2004	Motor <27.85
21 Burns (Burns)	2101	Motor >0
Special CMGs	5001	Short-stay cases, length of stay is 3 days or fewer
	5101	Expired, orthopedic, length of stay is 13 days or fewer
	5102	Expired, orthopedic, length of stay is 14 days or more

<i>RIC</i>	<i>CMG Number</i>	<i>CMG Description</i>
	5103	Expired, not orthopedic, length of stay is 15 days or fewer
	5104	Expired, not orthopedic, length of stay is 16 days or more

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

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

In the FY 2006 proposed rule (70 FR 30188, 30210), we proposed to use a weighted motor score index in assigning patients to CMGs, instead of the motor score index previously used that treated all components equally. We also proposed to change how the IRF PPS GROUPER software would assign a value for the transfer-to-toilet item when it is coded by the provider with a 0. We proposed that the software would assign this item a value of 2 instead of a 1 when the activity is coded by the provider with a 0. However, we proposed not to change the cognitive score index. As described in detail below, we continue to believe that a weighted motor score index, with the change to the scoring of the transfer to toilet item when the provider records a 0 value for the activity on the IRF-PAI, will improve the classification of patients into CMGs, which in turn will improve the accuracy of payments to IRFs.

To classify a patient into a CMG, IRFs use the

admission assessment data from the IRF-PAI to score a patient's functional independence measures. The functional independence measures consist of what are termed "motor" items and "cognitive" items. In addition to the functional independence measures, the patient's age may also influence the patient's CMG classification. The motor items are generally indications of the patient's physical functioning level. The cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. The motor items are eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, transfer to tub or shower, walking or wheelchair use, and stair climbing. The cognitive items are comprehension, expression, social interaction, problem solving, and memory. (The CMS IRF-PAI manual includes more information on these items.) Each item is generally recorded on the IRF-PAI and scored on a scale of 0 to 7, with a 7 indicating complete independence in this area of functioning, a 1 indicating that a patient is very impaired in this area of functioning, and a 0 indicating that the activity did not occur.

As explained in the August 7, 2001 final rule

(66 FR 41349), the instructions for the IRF-PAI required that providers record an 8 for an item to indicate that the activity did not occur, as opposed to a 1 through 7 indicating that the activity occurred and the estimated level of function connected with that activity. However, when the IRF-PAI form was finalized, the code 8 had been removed and was replaced with the code 0. Therefore, facilities now record a 0 when an activity does not occur.

To determine the appropriate payment for patients for whom an activity is coded as 0 (that is, the activity did not occur), we needed to decide an appropriate way of changing the 0 to another code for which payment could be assigned. As discussed in the August 7, 2001 final rule (66 FR at 41349), for purposes of classifying patients into CMGs, we decided to assign a code of 1 (indicating that the patient needed "total assistance") whenever a code of 0 appeared for one of the items on the IRF-PAI used to determine payment. This was the most conservative approach we could have taken based on the best available data at the time because a value of 1 indicates that the patient needed total assistance performing the task. The result of recoding a 0 as a 1 and using that value to classify a patient into a CMG is that the provider might receive a higher payment for that item (although it might not be the highest payment overall, depending on the patient's other

functional abilities and/or comorbidities).

In the FY 2006 proposed rule (70 FR 30188), we proposed to change the way we treat a code of 0 on the IRF-PAI for the transfer to toilet item. This is the only item that we proposed to change at this time because RAND's regression analysis demonstrated that, of all the motor score values, the evidence supporting a change in the motor score values was the strongest with respect to this item. We proposed to assign a code of 2, instead of a code of 1, to patients for whom a 0 is recorded on the IRF-PAI for the transfer to toilet item (as discussed below) because RAND's analysis of calendar year 2002 and FY 2003 data indicates that patients for whom a 0 is recorded are more similar in terms of their characteristics and costliness to patients with a recorded score of 2 than to patients with a recorded score of 1. We proposed to make this change to provide the most accurate payment for each patient.

Using regression analysis on the calendar year 2002 and FY 2003 data, which is more complete and provides more detailed information on patients' functional abilities than the FY 1999 data used to construct the IRF PPS (even though the 1999 data were the best available data at the time), RAND analyzed whether the assignment of 1 to items for which a 0 is recorded on the IRF-PAI continues to correctly assign payments based on patients' expected costliness. RAND

examined all of the items in the motor score index, focusing on how often a code of 0 appears for the item, how similar patients with a code of 0 are to other patients with the same characteristics that have a score of 1 through 7, and how much a change in the item's score affects the prediction of a patient's expected costliness. Based on RAND's regression analysis, we believed and continue to believe it is appropriate to change the assignment of 0 on the transfer to toilet item from a 1 to a 2 for the purposes of determining IRF payments.

Until now, the IRF PPS has used standard motor and cognitive scores, the sum of either 12 or 13 motor items and the sum of 5 cognitive items, to assign patients to CMGs. This summing equally weights the components of the indices.

These indices have been accepted and used for many years. Although the weighted motor score is an option that has been considered before, most experts believed that the data were not complete and accurate enough before the IRF PPS (although they were the most complete and accurate data available at the time). Now, it is believed that the data are complete and accurate enough to support using a weighted motor score index.

In developing candidate indices that would weight the items in the score, RAND had the following competing goals: developing indices that would increase the predictive power

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

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

RAND assessed different weighting methodologies for both the motor score index and the cognitive score index. They discovered that weighting the motor score index improved the predictive ability of the system, whereas weighting the cognitive score index did not. Furthermore, the cognitive score index has never had much of an effect (in some RICs, it has no effect) on the assignment of

patients to CMGs because the motor score tends to be much stronger at predicting a patient's expected costs in an IRF than the cognitive score.

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

Table 3 below shows the optimal weights from the regression analysis for the components of the motor score, averaged across all RICs and normalized to sum to 100.0, obtained through the regression analysis. The weights relate to the FIM items' relative ability to predict treatment costs. Table 3 indicates that dressing lower, toilet, bathing, and eating are the most effective self-care items for predicting costs; bowel and bladder control may not be effective at predicting costs; and that the items grouped in the transfer and locomotion categories might be somewhat more effective at predicting costs than the other categories.

We are making no changes to Table 3, which was Table 5 in the FY 2006 proposed rule (70 FR 30188, 30211).

Table 3—Optimal Weights, Averaged Across Rehabilitation Impairment Categories (RICs): Motor Items

<i>Item Type</i>	<i>Functional Independence Item</i>	<i>Average Optimal Weight</i>
Self	Dressing lower	1.4
Self	Toilet	1.2
Self	Bathing	0.9
Self	Eating	0.6
Self	Dressing upper	0.2
Self	Grooming	0.2
Sphincter	Bladder	0.5
Sphincter	Bowel	0.2
Transfer	Transfer to bed	2.2
Transfer	Transfer to toilet	1.4
Transfer	Transfer to tub	Not included
Locomotion	Walking	1.6
Locomotion	Stairs	1.6

Based on RAND's analysis, we considered a number of different candidate indices before we proposed using a weighted index. We considered defining some simple combinations of the four item types that make up the motor score index and assigning weights to the groups of items instead of to the individual items. For example, we considered summing the three transfer items together to form a group with a weight of two, since they contributed about twice as much in the cost regression as the self-care items.

We also considered assigning the self-care items a weight of one and the bladder and bowel items as a group a weight close to zero, since they contributed little to predicting cost in the regression analysis. We tried a number of variations and combinations of this, but RAND's TEP

generally rejected these weighting schemes. They believed that introducing elements of subjectivity into the development of the weighting scheme may invite controversy, and that it is better to use an objective algorithm to derive the appropriate weights. We agree that an objective weighting scheme is best because it is based on regression analysis of the amount that various components of the motor score index contribute to predicting patient costs, using the best available data we have. Therefore, we proposed to use a weighting scheme that applies the average optimal weights. To develop the weighting scheme, RAND used regression analysis to estimate the relative contribution of each item to the prediction of costs. Based on this analysis, we proposed the weighting scheme indicated in Table 3 above and in the following simple equation:

$$\begin{aligned} \text{Motor score index} = & 1.4 * \text{dressing lower} + 1.2 * \text{toilet} + \\ & 0.9 * \text{bathing} + 0.6 * \text{eating} + 0.2 * \text{dressing upper} + 0.2 * \text{grooming} \\ & + 0.5 * \text{bladder} + 0.2 * \text{bowel} + 2.2 * \text{transfer to bed} + \\ & 1.4 * \text{transfer to toilet} + 1.6 * \text{walking} + 1.6 * \text{stairs}. \end{aligned}$$

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

on average.

Public comments and our responses on the proposal to use a weighted motor score index and to change the treatment of unobserved transfer to toilet values are summarized below.

Comment: One commenter suggested that the optimal weights for the bladder and bowel items may be too low because incontinence is the most cited reason patients receive inpatient post-acute care.

Response: We believe that the weights for the bladder and bowel items are appropriate since they were determined based on regression analysis of the effects of these items on the prediction of IRF costs. The purpose of the optimal weights for the proposed weighted motor score index is not to indicate the reasons patients receive inpatient post-acute care but rather to estimate the influence of various motor score items on the expected costs of treating patients in the IRF setting. While we do not disagree that incontinence may be a significant reason that many patients receive post-acute care in an inpatient setting, the optimal weights described above were obtained from RAND's regression analysis of the functional items on patient costs using FY 2003 data.

Comment: Several commenters were concerned that the proposed weighted motor score is complex, creates added costs for providers, will require retraining of staff, is not sensitive to differences among RICs, and that RAND's

technical expert panel did not support the weighting methodology.

Response: We proposed a weighted motor score index because RAND's analysis indicates that a weighted motor score index will improve the classification of patients into CMGs, which in turn will improve the accuracy of payments to IRFs.

As we stated earlier, in developing candidate indices that would weight the items in the score, RAND had competing goals: to develop indices that would increase the predictive power of the system while at the same time maintaining simplicity and transparency in the payment system. For example, they found that an "optimal" weighting methodology from the standpoint of predictive power would require computing 378 different weights (18 different weights for the motor and cognitive indices that could all differ across 21 RICs). Although this would have made the score more sensitive to differences among RICs, as the commenter requested, it would have made the score substantially more complex and less transparent. Thus, we proposed a weighting methodology that balances these two competing goals.

With regard to the commenter's statement regarding the lack of support for the weighting methodology, RAND's technical expert panel generally endorsed the particular weighting methodology we proposed to implement. Furthermore, in the technical expert panel's discussions, participants told RAND that the weighting methodology would

not be difficult for providers to implement. They stated that providers typically have software that computes the motor score, and that software would only require slight modifications to accommodate the new weighting methodology.

Staff members in IRFs that complete the patient assessments would continue to input the same information they currently do into the software and therefore, in general, staff should not need to be retrained. We are not proposing any changes to how providers code items on the IRF-PAI, only how the information is used to classify patients into CMGs for determining the payment rate. We wish to point out that the weighted motor score for classifying patients into CMGs will be computed automatically by the GROUPER software, not by a clinician. CMS will issue the new GROUPER software at no cost to providers, and the new GROUPER software can be used in the same manner as the old GROUPER software. Thus, the proposed change to the weighted motor score index would not be expected to add to providers' costs. However, CMS will assist providers in any training efforts that may be required to implement the proposed new weighting methodology.

Comment: Two commenters raised concerns regarding the proposed change in assignment of the transfer-to-toilet item. They indicated that this change could artificially elevate the motor score, reduce payments, and have a negative impact on severely ill patients, specifically spinal cord injury patients.

Response: We proposed to assign the transfer-to-toilet item on the IRF-PAI a value of 2, instead of 1, when the provider has recorded a value of 0 (meaning the activity did not occur) because RAND's regression analysis of calendar year 2002 and FY 2003 data indicates that patients for whom a 0 is recorded are more similar in terms of their characteristics and costliness to patients with a recorded score of 2 than to patients with a recorded score of 1. We proposed to make this change in order to provide the most accurate payment for each patient.

We do not believe this proposed change will have a significant effect on payment or on access to care for patients for the following reasons: (1) the transfer-to-toilet item is only 1 of 12 items that make up the motor score index, (2) we are only proposing to change the score on this item by 1 point (which results in a 1.4 increase to the weighted motor score index), and (3) this change will only affect those patients for whom a 0 is recorded for this item (only about 2.8 percent of all IRF cases RAND examined).

Furthermore, the payment for a particular patient with a 0 value for this item would only change if the proposed 1.4 point increase in the motor score index changes the patient's CMG classification. For this to happen, the patient's motor score would have to be within 1.4 points of a CMG boundary. In particular, as the commenter noted the example of spinal cord injury patients, we will use RIC 04

(traumatic spinal cord injury) as an example. The difference in motor scores values that would qualify a patient for CMG 0402 versus CMG 0401 is 18.1 points, and the difference in motor scores values that would qualify a patient for CMG 0403 versus CMG 0402 is 14.3 points. Because these ranges are relatively large, we believe patients will rarely change CMGs as a result of a 1.4 point increase in the motor score index.

We proposed this change in coding of the transfer-to-toilet item because, based on RAND's analysis, we believe this proposed change will improve the accuracy of payments in the IRF PPS. As always, we are concerned that all patients have appropriate access to IRF services. Accordingly, we will monitor the impact of this proposed change and the other proposed changes to the IRF classification system finalized in this final rule to ensure that patients continue to have adequate access to IRF care.

Comment: One commenter was concerned that the weighted motor score might disproportionately affect IRF payments for certain types of patients with certain conditions, such as cognitively impaired patients with significant lower body impairments or with significant dysfunctions in upper body and bladder/bowel problems.

Response: We do not believe the weighted motor score methodology will have a disproportionate affect on any particular groups of patients. RAND's data analysis and RAND's technical expert panel did not raise any concerns

regarding any particular groups of patients that would be unduly affected by these changes. We believe that the types of patients the commenter mentioned were included in the data RAND used to determine the optimal weights for the weighted motor score and to calibrate the appropriate payments. The purpose of the proposed weighted motor score, as with all of the proposed changes discussed in this final rule, is to align payments more appropriately with the costs of caring for all types of patients in IRFs. CMS will continue to closely monitor the data to ensure that no groups of patients are disproportionately affected by the change to a weighted motor score index.

Comment: One commenter indicated that CMS, in proposing to implement the weighted motor score, did not seek enough review from experts who developed and researched the FIM items.

Response: As discussed in this final rule under section IV, we contracted with RAND to examine potential refinements to the IRF PPS. RAND sought advice from a technical expert panel, which reviewed their methodology and findings regarding the proposed weighted motor score methodology and generally endorsed the methodology we proposed in the FY 2006 proposed rule (70 FR 30188). RAND's technical expert panel included representatives from industry groups, other government entities, academia, and other researchers, including members with expertise in the FIM items. Thus, we believe RAND sought sufficient review

from experts in the field in developing the proposed weighted motor score methodology.

Comment: One commenter requested that CMS remove the transfer to tub item from the IRF-PAI, to reduce the length of the form, because the transfer-to-tub item is not used in classifying patients into CMGs for payment purposes.

Response: We did not propose any changes to the IRF-PAI. However, we will take this comment into consideration in future reviews of the IRF-PAI. We would need to more fully consider the benefits and costs of removing this item from the IRF-PAI form to determine if this change is appropriate.

Final Decision: After carefully considering all of the comments we received on the proposed weighted motor score methodology, we are finalizing our decision to adopt the methodology as described above. Specifically, the weighted motor score index will be computed using the following equation:

$$\begin{aligned} \text{Motor score index} = & 1.4 * \text{dressing lower} + 1.2 * \text{toilet} + \\ & 0.9 * \text{bathing} + 0.6 * \text{eating} + 0.2 * \text{dressing upper} + 0.2 * \text{grooming} \\ & + 0.5 * \text{bladder} + 0.2 * \text{bowel} + 2.2 * \text{transfer to bed} + \\ & 1.4 * \text{transfer to toilet} + 1.6 * \text{walking} + 1.6 * \text{stairs}. \end{aligned}$$

In addition, we are finalizing our decision to reassign a value of 2 instead of 1 when providers code a 0 for the transfer-to-toilet item on a patient's IRF-PAI. Based on RAND's regression analysis of FY 2003 data, the best data

available for analysis, we believe these changes will increase the accuracy of IRF PPS payments.

3. Changes to the Relative Weights

In the FY 2006 proposed rule (70 FR 30188), we proposed to update the relative weights assigned to each CMG.

Section 1886(j)(2)(B) of the Act requires that an appropriate relative weight be assigned to each CMG.

Relative weights that account for the variance in cost per discharge and resource utilization among payment groups are a primary element of a case-mix adjusted prospective payment system. The accuracy of the relative weights helps to ensure that payments reflect as much as possible the relative costs of IRF patients and, therefore, that beneficiaries have access to care and receive the appropriate services.

Section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment to IRFs is made, and other factors which may affect the relative use of resources. In accordance with this section of the Act, we proposed to recalculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative

weight of 2, on average, would cost twice as much as cases in a CMG with a relative weight of 1. We did not propose to change the methodology for calculating the relative weights, as described in the August 7, 2001 final rule (66 FR 41316, 41351 through 41353) and consequently, we only proposed to update the relative weights themselves.

As previously stated, we believe that improved coding of data, the availability of more complete data, and changes to the tier comorbidities and CMGs helped us decide to propose to update the relative weights assigned to the CMGs so that they could continue to accurately represent the differences in costs across CMGs and across tiers.

Therefore, we proposed to recalculate the relative weights.

However, we proposed no change to the methodology for calculating the relative weights. Instead, we proposed to update the relative weights (the relative weights that are multiplied by the standard payment conversion factor to assign relative payments for each CMG and tier) using the same methodology as described in the August 7, 2001 final rule (66 FR 41316, 41351 through 41353) and as noted previously in section V.C.3 of this final rule, using FY 2003 Medicare billing data. To summarize, we proposed to use the following basic steps to update the relative weights: The first step in calculating the CMG weights is to estimate the effects that comorbidities have on costs.

The second step is to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step are used to calculate "relative adjusted weights" in each CMG using the hospital-specific relative value method.

The final steps are to calculate the CMG relative weights by modifying the "relative adjusted weight" with the effects of the existence of the comorbidity tiers (explained below) and normalize the weights to 1.

We proposed to make the tier and the CMG changes in such a way that total estimated aggregate payments to IRFs for FY 2006 would be the same with or without the changes (that is, in a budget neutral manner) for the following reasons. First, we believe that the results of RAND's analysis of 2002 and 2003 IRF cost data suggest that additional money does not need to be added to the IRF PPS. RAND's analysis found, for example, that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. Furthermore, RAND did not find evidence that the overall costliness of patients (average case mix) in IRFs increased substantially in 2002 compared with 1999. As discussed in detail in section VI.A of this final rule, RAND found that real case

mix increased by at most 1.5 percent, and may have decreased by as much as 2.4 percent. The available evidence, therefore, suggests that IRF PPS payments, in aggregate, are likely adequate to pay for the types of patients IRFs treat.

The purpose of the CMG and tier changes is to ensure that the existing resources already in the IRF PPS are distributed better among IRFs according to the relative costliness of the types of patient they treat. Section 1886(j)(2)(C)(i) of the Act confers broad statutory authority upon the Secretary to adjust the classification and weighting factors to account for relative resource use.

Consistent with that broad statutory authority, we proposed to update the relative weights to more accurately reflect the IRF case mix.

To ensure that total estimated aggregate payments to IRFs do not change, we proposed to apply a factor to the standard payment amount to ensure that estimated aggregate payments due to the proposed changes to the tier comorbidities, the CMGs, the weighted motor score, and the relative weights for FY 2006 are not greater or less than those that would have been made in FY 2006 without the proposed changes. In section VI.B.7 and section VI.B.8 of this final rule, we discuss the methodology and factor we proposed to apply to the standard payment amount.

Public comments and our responses on the proposed changes for updating the relative weights are summarized below.

Comment: Several commenters noted that, in many of the CMGs, the average length of stay has decreased. One commenter suggested that there might have been inconsistencies between the relative weights and the average length of stay values reported in the proposed Table 6 in the FY 2006 proposed rule (70 FR 30188, 30213 through 30219).

Response: RAND's analysis found that the average length of stay in IRFs has decreased substantially in recent years. This decrease is reflected in the average length of stay values for most of the CMGs in the proposed Table 6 in the FY 2006 proposed rule (70 FR 30188, 30213 through 30219). However, with the exception of determining IRF payments in certain transfer cases, the average length of stay does not affect IRF payments. CMS does not require IRFs to treat these average length of stay values as goals or targets for particular cases. IRFs are generally free to treat particular patients for as few or as many days as they deem medically appropriate. We encourage IRFs to admit patients for the length of time that results in the best quality of care for the patient. The length of stay portion of the proposed Table 6 in the FY 2006 proposed rule (70 FR 30188, 30213 through 30219) is provided for informational purposes only.

The relative weights for each of the CMGs and tiers represent the relative costliness of patients in those CMGs and tiers compared with patients in other CMGs and tiers. The average length of stay for each CMG and tier represents the average number of days patients in that CMG and tier were treated in IRFs, based on the FY 2003 data. IRF PPS payments are determined on a per-discharge basis, meaning that providers are paid a pre-determined payment amount according to that patient's CMG and tier classification, regardless of the number of days the patient is treated in the IRF. The only exceptions to this general policy are for very short-stay cases and for certain transfer cases. Because payments are made on a per-discharge basis, there is not necessarily any correlation between the number of days a patient is treated in the IRF and the payment amount for that patient. If, for example, the relative weight for a particular CMG in tier 1 is higher than the relative weight for that same CMG in the no-comorbidity tier, this means that cases in that CMG in tier 1 are expected to be more costly for the IRF to treat than cases in that CMG in the no-comorbidity tier. The average length of stay for patients in that CMG in tier 1, however, could be lower than the average length of stay of patients in that CMG in the no-comorbidity tier because the treatment for patients in that CMG in tier 1 could be much more intensive for a shorter period of time than the treatment for patients in the no-comorbidity tier, who could require less-intensive

treatment over a longer period of time. Thus, the relative weights may not bear a relationship to the length of stay, and the two need not be consistent with each other.

Comment: Several commenters expressed concerns about decreases in the relative weights for certain CMGs, particularly for the stroke and traumatic brain injury CMGs.

These commenters stated that, if the relative weights and, consequently, the payment rates for certain CMGs were to decrease, it could potentially lead to reduced access to IRF care for patients in the affected CMGs.

Response: The commenters were not clear as to which CMG weights they were using as a comparison with the proposed FY 2006 relative weights in Table 6 of the FY 2006 proposed rule (70 FR 30188, 30213 through 30219). We believe that the commenter was comparing the proposed FY 2006 relative weights published in the FY 2006 proposed rule (70 FR 30188, 30213 through 30219) to the FY 2005 relative weights published in the July 30, 2004 notice updating the payment rates (69 FR 45721). Because we proposed revised definitions of the CMGs, as described in section V.C.1 of this final rule, the proposed new relative weights for the proposed new CMGs cannot be compared with the FY 2005 relative weights based on the FY 2005 CMG definitions. The types of patients included in each CMG, as defined in Table 4 and Table 6 of the FY 2006 proposed rule (70 FR 30188, 30207 through 30210, 30213 through 30219) are

likely not the same patients included in the CMGs under the FY 2005 CMG definitions.

Furthermore, as previously stated, the improved coding of data, the availability of more complete data, proposed changes to the tier comorbidities and CMGs, and changes in IRF cost structures contributed to our decision to propose to update the relative weights assigned to the CMGs so that the weights continue to represent the differences in costs across CMGs and across tiers. For these reasons, we have proposed to recalculate the relative weights to ensure that IRF payments remain aligned as closely as possible with the costs of care. We will continue to monitor beneficiaries' access to IRF care to ensure that the changes to the IRF classification system noted in this final rule do not impede access to IRF care for Medicare beneficiaries in general or for beneficiaries with any particular conditions. In particular, we believe it is important to ensure that stroke patients have appropriate access to rehabilitation services, as this population benefits considerably from receiving prompt rehabilitation care.

Nevertheless, we asked RAND to review the average relative weights for the stroke and traumatic brain injury RICs both under the FY 2005 CMG definitions and under the proposed new CMG definitions. The average relative weights were essentially identical within these two RICs, meaning that providers would use essentially the same relative weight to calculate payments for an "average" stroke patient

and an "average" traumatic brain injury patient in FY 2006 as they used to calculate payments for the "average" stroke patient and the "average" traumatic brain injury patient in FY 2005. We believe, based on RAND's regression analysis of FY 2003 data, that the proposed changes to the classification system will improve the alignment of IRF payments with the costs of care and, thereby, improve access to care for IRF patients.

Comment: One commenter stated that if the proposed recalculation of the relative weights were to result in lower payments for some patients and, therefore, were to lead to payments that did not adequately cover treatment costs for those patients, then patients' access to IRF care might suffer. A couple of commenters requested that CMS phase in the proposed changes to the classification system.

Response: We considered proposing a phase in of the proposed changes to the classification system, but we believe a phase in of the changes would have introduced undue complication to the classification system because it would have required individual providers, fiscal intermediaries, and CMS to compute two different sets of CMGs to determine payments.

The intent of the proposed changes to the IRF classification system, including the proposed recalculation of the relative weights, was to ensure that IRF payments are aligned as closely as possible with the costs of care. We

believe these proposed revisions will help us to ensure that IRF payments and costs continue to be aligned as appropriately as possible. We will continue to monitor beneficiaries' access to IRF care to ensure that the payment system continues to provide such access to IRF care.

To assist providers in adopting the changes to the classification system we are finalizing in this final rule, we will make the new GROUPER and PRICER software available for download on the CMS website as soon as possible and before implementation of the final changes. Furthermore, our analysis of the impacts, detailed in section XII of this final rule, indicate that aggregate effects on provider payments of the proposed changes are expected to be small.

Comment: One commenter noted that the proposed relative weights for the burn CMG (CMG 2101) for tier 1 and tier 2 are the same. The commenter asked whether this could be an error.

Response: This was not an error. The FY 2003 data do not contain enough patients in CMG 2101 in tiers 1 and 2 to estimate precise relative weights for each tier. Accordingly, RAND combined patients in these two tiers to estimate the proposed and final relative weights for both tiers.

Comment: Several commenters requested that CMS make available to the public the patient-level data on CMG assignments, the IRF-PAI data, the MedPAR files, and the

cost report data RAND used for their analysis to enable the public to replicate RAND's analysis.

Response: The data files the commenters requested are generally available (and were generally available during the comment period for the FY 2006 proposed rule) through CMS's standard data distribution systems. Please refer to CMS's website at <http://www.cms.hhs.gov/researchers/statsdata.asp> for more information about obtaining data from CMS.

Comment: One commenter asked if CMS could provide the standard deviation information for the average length of stay information listed for each CMG and tier.

Response: We will consider posting this type of information on our website.

Comment: One commenter noted the operational challenges, such as the large number of revisions that need to be made to the GROUPER software, of implementing the changes to the IRF classification system that CMS has proposed and further requested that CMS make available the new CMG GROUPER to the public.

Response: We agree with the commenter that the operational issues of implementing the proposed changes to the classification system may be challenging, but we will provide the necessary assistance to ensure a smooth transition to the new tiers and CMGs, the new weighted motor score methodology, and the new relative weights. As is our practice, we will make the new GROUPER and PRICER software available for download on the CMS website as soon as

possible and prior to implementation of the finalized changes. In addition, we will evaluate whether provider, fiscal intermediary, or regional office training may be required to promote understanding of any final changes and assist in the implementation of such changes. Our foremost goal will be to ensure a smooth implementation of changes because we believe that any final changes to the classification system will improve the accuracy of payments in the IRF PPS.

Comment: Several commenters requested that CMS evaluate the effects of the proposed changes to the IRF classification system after the changes are implemented and propose additional refinements to the classification system in future years, if necessary.

Response: We agree with the commenter that it will be important to evaluate the effects of any changes to the classification system to ensure that IRF payments continue to be aligned as closely as possible with the costs of care.

CMS intends to monitor the data carefully to ensure that patients who require inpatient rehabilitation services have adequate access to these services. We will propose refinements if, in the future, we later identify the need to make modifications to the classification system to ensure that IRF payments remain aligned with the costs of care.

Final Decision: After carefully considering all the comments we received on the proposed re-calculation of the relative weights, we are finalizing our proposal to adopt

the relative weights presented in Table 4, without change. However, we note that, after reviewing the average length of stay values in response to the comments we received, we have made a slight revision to the methodology for computing the average length of stay values reported in Table 4 to be consistent with the way we presented average length of stay values in the August 7, 2001 final rule (66 FR 41316).

Table 4 -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>51.05	0.7691	0.7299	0.6484	0.6350	8	11	9	9
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9471	0.8989	0.7985	0.7820	11	15	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1162	1.0594	0.9411	0.9217	14	13	12	12
0104	Stroke M>38.85 and M<44.45	1.1859	1.1255	0.9999	0.9792	13	14	13	13
0105	Stroke M>34.25 and M<38.85	1.4233	1.3509	1.2001	1.1753	16	17	15	15
0106	Stroke M>30.05 and M<34.25	1.6567	1.5724	1.3969	1.3680	18	20	18	18
0107	Stroke M>26.15 and M<30.05	1.9121	1.8148	1.6122	1.5790	21	23	20	21
0108	Stroke M<26.15 and A>84.5	2.2106	2.0981	1.8639	1.8254	27	29	24	24
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.1976	2.0858	1.8529	1.8147	23	26	24	23
0110	Stroke M<22.35 and A<84.5	2.6262	2.4926	2.2143	2.1686	30	33	28	28

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
0201	Traumatic brain injury M>53.35 and C>23.5	0.8140	0.6826	0.6021	0.5648	10	9	9	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0437	0.8753	0.7720	0.7241	12	10	11	9
0203	Traumatic brain injury M>44.25 and C<23.5	1.2487	1.0472	0.9236	0.8664	15	15	12	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.3356	1.1201	0.9879	0.9267	15	16	13	13
0205	Traumatic brain injury M>28.75 and M<40.65	1.6381	1.3738	1.2116	1.1365	17	18	16	15
0206	Traumatic brain injury M>22.05 and M<28.75	2.1379	1.7930	1.5814	1.4833	23	22	21	20
0207	Traumatic brain injury M<22.05	2.7657	2.3194	2.0457	1.9188	35	29	26	25
0301	Non-traumatic brain injury M>41.05	1.1293	0.9536	0.8440	0.7764	12	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.4729	1.2438	1.1008	1.0126	14	16	14	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.7575	1.4841	1.3136	1.2083	20	19	17	16
0304	Non-traumatic brain injury M<26.15	2.4221	2.0453	1.8103	1.6651	31	25	23	21
0401	Traumatic spinal cord injury M>48.45	0.9891	0.8517	0.7656	0.6837	12	12	10	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3640	1.1746	1.0558	0.9428	19	16	14	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.3743	2.0446	1.8379	1.6412	22	24	23	22

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
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.2567	3.6656	3.2950	2.9424	51	46	39	37
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.2477	2.7967	2.5139	2.2449	32	38	33	28
0501	Non-traumatic spinal cord injury M>51.35	0.7705	0.6449	0.5641	0.5059	9	8	8	7
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0316	0.8634	0.7553	0.6774	13	12	10	9
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3676	1.1446	1.0013	0.8979	15	15	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.7120	1.4328	1.2534	1.1240	20	19	16	15
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0289	1.6981	1.4855	1.3321	23	22	19	18
0506	Non-traumatic spinal cord injury M<23.75	2.7607	2.3106	2.0212	1.8126	29	28	25	23
0601	Neurological M>47.75	0.8965	0.7331	0.6966	0.6493	11	10	9	9
0602	Neurological M>37.35 and M<47.75	1.1925	0.9752	0.9267	0.8636	13	13	12	12
0603	Neurological M>25.85 and M<37.35	1.5266	1.2484	1.1863	1.1056	16	17	15	15
0604	Neurological M<25.85	1.9539	1.5979	1.5183	1.4151	22	20	20	19
0701	Fracture of lower extremity M>42.15	0.9055	0.7736	0.7265	0.6585	12	11	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1757	1.0044	0.9432	0.8549	13	14	13	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.4636	1.2504	1.1742	1.0643	16	17	15	14

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
0704	Fracture of lower extremity M<28.15	1.7962	1.5345	1.4410	1.3062	20	20	19	18
0801	Replacement of lower extremity joint M>49.55	0.6561	0.5511	0.5109	0.4596	7	7	7	6
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8570	0.7198	0.6673	0.6004	10	10	9	8
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0672	0.9894	0.8901	15	15	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1069	0.9296	0.8618	0.7754	13	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3937	1.1705	1.0852	0.9763	17	16	14	13
0806	Replacement of lower extremity joint M<22.05	1.6726	1.4047	1.3023	1.1716	18	19	17	15
0901	Other orthopedic M>44.75	0.8412	0.7658	0.6805	0.6090	10	11	10	9
0902	Other orthopedic M>34.35 and M<44.75	1.1054	1.0063	0.8942	0.8002	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4583	1.3276	1.1797	1.0557	18	19	16	15
0904	Other orthopedic M<24.15	1.8281	1.6643	1.4788	1.3234	25	23	20	19
1001	Amputation, lower extremity M>47.65	0.9638	0.8888	0.7931	0.7312	11	11	11	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1719	1.0457	0.9641	14	15	14	13
1003	Amputation, lower extremity M<36.25	1.7876	1.6483	1.4709	1.3561	19	22	19	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
1101	Amputation, non-lower extremity M>36.35	1.2544	1.0496	0.9189	0.8462	14	15	12	11
1102	Amputation, non-lower extremity M<36.35	1.8780	1.5713	1.3756	1.2668	19	19	18	17
1201	Osteoarthritis M>37.65	1.0184	0.8794	0.8106	0.7317	11	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.3181	1.1383	1.0492	0.9470	15	16	14	13
1203	Osteoarthritis M<30.75	1.6238	1.4022	1.2925	1.1666	21	19	17	16
1301	Rheumatoid, other arthritis M>36.35	1.0338	0.9617	0.8325	0.7358	12	13	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4324	1.3325	1.1534	1.0195	15	18	15	14
1303	Rheumatoid, other arthritis M<26.15	1.8308	1.7032	1.4743	1.3032	22	21	20	18
1401	Cardiac M>48.85	0.8172	0.7352	0.6396	0.5806	10	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1034	0.9926	0.8636	0.7839	12	13	12	11
1403	Cardiac M>31.15 and M<38.55	1.3735	1.2356	1.0750	0.9759	16	16	14	13
1404	Cardiac M<31.15	1.7419	1.5671	1.3633	1.2376	21	20	18	16
1501	Pulmonary M>49.25	0.9222	0.8995	0.7687	0.7397	11	12	10	10
1502	Pulmonary M>39.05 and M<49.25	1.1659	1.1371	0.9718	0.9352	12	15	12	12
1503	Pulmonary M>29.15 and M<39.05	1.4269	1.3917	1.1894	1.1445	12	17	15	15
1504	Pulmonary M<29.15	1.8812	1.8348	1.5681	1.5089	21	22	20	18
1601	Pain syndrome M>37.15	1.0065	0.8544	0.7731	0.6904	12	11	10	9
1602	Pain syndrome M>26.75 and M<37.15	1.3810	1.1724	1.0607	0.9473	15	17	14	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
1603	Pain syndrome M<26.75	1.6988	1.4421	1.3048	1.1653	19	19	17	16
1701	Major multiple trauma without brain or spinal cord injury M>39.25	1.0102	0.9634	0.8323	0.7321	12	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.3305	1.2688	1.0962	0.9643	14	16	15	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5832	1.5098	1.3043	1.1474	17	20	17	16
1704	Major multiple trauma without brain or spinal cord injury M<25.55	1.9808	1.8889	1.6319	1.4355	26	26	21	20
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.2118	0.9832	0.8245	0.7282	15	13	12	10
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9385	1.5728	1.3190	1.1649	20	21	18	16
1803	Major multiple trauma with brain or spinal cord injury M<23.05	3.4784	2.8222	2.3668	2.0903	43	33	30	27
1901	Guillian Barre M>35.95	1.2362	1.0981	1.0677	0.9349	14	13	14	12
1902	Guillian Barre M>18.05 and M<35.95	2.3162	2.0574	2.0004	1.7515	27	25	24	23
1903	Guillian Barre M<18.05	3.3439	2.9703	2.8881	2.5287	37	39	31	33
2001	Miscellaneous M>49.15	0.8743	0.7387	0.6623	0.6047	10	10	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1448	0.9672	0.8671	0.7917	12	13	11	11

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
2003	Miscellaneous M>27.85 and M<38.75	1.4789	1.2495	1.1202	1.0227	16	16	15	14
2004	Miscellaneous M<27.85	1.9756	1.6692	1.4964	1.3663	25	22	20	18
2101	Burns M>0	2.1858	2.1858	1.5910	1.4762	29	24	19	17
5001	Short-stay cases, length of stay is 3 days or fewer				0.2201				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.6002				22
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.7204				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8771				24

Based on RAND's regression analysis of FY 2003 data, the best data available for analysis, we believe these changes will increase the accuracy of IRF PPS payments.

VI. FY 2006 Federal Prospective Payment Rates

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

In the FY 2006 proposed rule (70 FR 30188), we proposed to reduce the standard payment amount by 1.9 percent to account for coding changes. Section 1886(j)(2)(C)(ii) of

the Act requires the Secretary to adjust the per payment unit payment rate for IRF services to eliminate the effect of coding or classification changes that do not reflect real changes in case mix if the Secretary determines that changes in coding or classification of patients have resulted or will result in changes in aggregate payments under the classification system. As described below, in accordance with this section of the Act and based on research conducted by RAND under contract with us, we proposed to reduce the standard payment amount for patients treated in IRFs by 1.9 percent.

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

to coding. We believe that changes in payment amounts should accurately reflect changes in IRFs' patient case mix (that is, the true cost of treating patients), and should not be influenced by changes in coding practices.

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

For example, an 80-year old hip replacement patient with a motor score between 47 and 54 and no comorbidities would be assigned to a particular CMG and tier based on these characteristics. The CMG and tier to which he is assigned would have an associated relative weight, in this case 0.5511 in FY 2005 (69 FR at 45725). This relative weight would be multiplied by the standard payment conversion factor of \$12,958 to equal the payment of \$7,141 in FY 2005 ($0.5511 \times \$12,958 = \$7,141$). However, based on the following discussion, we are lowering the standard payment amount by 1.9 percent to account for coding changes,

as opposed to real case mix changes, that have increased payments to IRFs.

As described in the August 7, 2001 final rule, we contracted with RAND to analyze IRF data to support our efforts in developing the classification system and the IRF PPS. We have continued our contract with RAND to support us in developing potential refinements to the classification system and the PPS for the FY 2006 proposed rule (70 FR 30188) and this final rule. As part of this research, we asked RAND to examine changes in case mix and coding since the IRF PPS. To examine these changes, RAND compared 2002 data from the first year of implementation of the PPS with the 1999 (pre-PPS) data used to construct the IRF PPS.

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

In addition, such review was necessary because, as explained below, we believe that the implementation of the

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

Although we believe implementation of the IRF PPS resulted in changes to how the patient assessment data have been coded, implementation of the IRF PPS may have also caused changes in case mix because it increased incentives for IRFs to take patients with greater impairment, lower function, or comorbidities. Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248), IRFs were paid on the basis of Medicare reasonable costs limited by a facility-specific target amount per discharge. IRFs were paid on a per discharge basis without per discharge adjustments being made for the impairments, functional status, or comorbidities of patients. Thus, IRFs had a strong incentive to admit less costly patients to ensure that the costs of treating patients did not exceed their

TEFRA payments. Under the IRF PPS, however, IRFs' PPS payments are tied directly to the principle diagnosis and accompanying comorbidities of the patient. Thus, based on the characteristics of the patients (that is, impairments, functional status, and comorbidities), the more costly the patient is expected to be, the higher the PPS payment. Therefore, IRFs may have greater incentives than they had under TEFRA to admit more costly patients.

Thus, in light of these concerns, RAND performed an analysis using IRF Medicare claims data matched with FIM and IRF-PAI data. Comparing 2002 data (post-PPS) with 1999 data (pre-PPS), RAND found that the observed case mix the expected costliness of patients—in IRFs increased by 3.4 percent between the two time periods. Thus, we paid 3.4 percent, or about \$140 million, more than expected during 2002 because of changes in the classification of cases in IRFs. However, RAND found little evidence that the patients admitted to IRFs in 2002 had higher resource needs (that is, more impairments, lower functioning, or more comorbidities) than the patients admitted in 1999. In fact, most of the changes in case mix that RAND documented from the acute care hospital records implied that IRF patients should have been less costly to treat in 2002 than in 1999. For example, RAND found a 16 percent decrease in the proportion of patients treated in IRFs following acute hospitalizations

for stroke, when it compared the results of the 2002 data with the 1999 data. Stroke patients tend to be relatively more costly than other types of patients for IRFs because they tend to require more intensive services than other types of patients. A decrease in the proportion of stroke patients relative to other types of patients, therefore, would likely contribute to a decrease in the overall expected costliness of IRF patients. RAND also found a 22 percent increase in the proportion of cases treated in IRFs following a lower extremity joint replacement. Lower extremity joint replacement patients tend to be relatively less costly for IRFs than other types of patients because their care needs tend to be less intensive than other types of patients. For this reason, the increase in the proportion of these patients treated in IRFs would suggest a decrease in the overall expected costliness of IRF patients.

We asked RAND to quantify the amount of the case mix change that was due to real case mix change (that is, the extent to which IRF patients had more impairments, lower functioning, or more comorbidities) and the amount that was due to coding. However, while the data permit RAND to observe the total change in expected costliness of patients over time with some precision, estimating the amount of this total change that is real and the amount that is due to coding generally cannot be done with the same level of

precision. Therefore, in order to quantify the amounts that were due to real case mix change and the amounts that were due to coding, RAND used two approaches to give a range of estimates within which the correct estimates would logically fall--(1) one that potentially underestimates the amount of real case mix change and overestimates the amount of case mix change due to coding; and (2) one that potentially overestimates real change and underestimates change due to coding. These two approaches give us a range of estimates, which should logically border the actual amount of real case mix and coding change. The first approach uses the following assumptions:

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

To illustrate this point, suppose, for example, that the IRF records showed that there were a greater number of patients with a pulmonary condition in IRFs in 2002 than in 1999. Patients with a pulmonary condition tend to be

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

Thus, if RAND found a substantial increase in the number of IRF patients with a pulmonary condition in the acute care hospital before going to the IRF, it would be reasonable to assume that more patients with a pulmonary condition were going to IRFs (a real increase in case mix). However, if there was little change in the number of IRF patients with a pulmonary condition in the acute care hospital before going to the IRF, then we believe it is reasonable to assume that a portion of the increase in patients with a pulmonary condition in IRFs was due to the incentives to code more of these patients in the IRFs.

We believe that this first approach shows that both factors, real case mix change and coding change, contributed to the amount of observed change in 2002, the first IRF PPS rate year. However, these estimates (based on the best available data) do not fully address all of the variables that may have contributed to the change in case mix. For example, the model does not account for the possibility that patients could develop impairments, functional problems, or comorbidities after they leave the acute care hospital (prior to the IRF admission) that would make them more costly when they are in the IRF. We note that the introduction of a new payment system may have interrelated effects on providers as they adapt to new (or perceived) program incentives. Thus, an analysis of first year

experience may not be fully representative of providers' behavior under a fully implemented system. In addition, hospital coding practices may change at a different rate in facilities where the IRF is a unit of an acute care hospital compared with freestanding IRF hospitals. Finally, we want to ensure that the rate reduction will not have an adverse effect on beneficiaries' access to IRF care.

For the reasons described above, we believed and continue to believe that we should provide some flexibility to account for the possibility that some of the observed changes may be attributable to other than coding changes. Thus, in determining the amount of the reduction in the standard payment amount, we examined RAND's second approach that recognizes the difficulty of precise measurement of real case mix and coding changes. Using this second approach, RAND developed an analytical procedure that allowed them to distinguish more fully between real case mix change and coding change based on patient characteristics. In part, this second approach involves analyzing some specific examples of coding that we know have changed over time, such as direct indications of improvements in impairment coding, changes in coding instruction for bladder and bowel functioning, and dramatic increases in coding of certain conditions that affect patients' placement into tiers (resulting in higher payments).

Using the two approaches, RAND found that real case mix changes in IRFs over this period ranged from a decrease of 2.4 percent (using the first approach) to an increase of 1.5 percent (using the second approach). This suggests that coding changes accounted for between 1.9 percent (if real case mix increased by 1.5 percent (that is, 3.4 percent minus 1.5 percent)) and 5.8 percent (if real case mix decreased by 2.4 percent (that is, 3.4 percent plus 2.4 percent)) of the increase in aggregate payments for 2002 compared with 1999. Thus, RAND recommended decreasing the standard per discharge payment amount by between 1.9 and 5.8 percent to adjust for the coding changes. We proposed to reduce the standard payment amount by the lower of these two numbers, 1.9 percent, because we believe it is a reasonable estimate for the amount of coding change, based on RAND's analysis of direct indications of coding change. That is, RAND analyzed specific examples of coding that we know have changed over time, such as direct indications of improvements in impairment coding, changes in coding instructions for bladder and bowel functioning, and dramatic increases in coding of certain conditions that affect patients' placement into tiers (resulting in higher payments) in deriving the 1.9 percent estimate.

We considered proposing a reduction to the standard payment amount by an amount up to 5.8 percent because RAND's

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

We decided to propose a reduction of 1.9 percent, the lowest possible amount of change attributable to coding change. The analyses described here are only the first of an ongoing series of studies to evaluate the existence and extent of payment increases due to coding changes. We will continue to review the need for any further reduction in the standard payment amount in subsequent years as part of our overall monitoring and evaluation of the IRF PPS.

Therefore, for FY 2006, we proposed to reduce the standard payment amount by the lowest amount (1.9 percent) attributable to coding changes. We believe this approach, which is supported by RAND's analysis of the data, will adequately adjust for the increased payments to IRFs caused by purely coding changes, but will still provide the flexibility to account for the possibility that some of the

observed changes in case mix may be attributed to other than coding changes. Furthermore, we chose to propose a 1.9 percent reduction in the standard payment amount to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the "75 percent rule."

Public comments and our responses on the proposed reduction of the standard payment amount to account for coding changes are summarized below.

Comment: Several commenters objected to CMS implementing an across the board reduction to payment rates to account for coding changes until the full impact of CMS's recent decision to enforce the 75 percent rule is known. These commenters generally also noted that RAND's analysis was based on 2002 data, which was the year facilities were transitioning to the IRF PPS.

Response: We believe a 1.9 percent reduction to the standard payment amount to account for coding changes is appropriate at this time for the following reasons. First, CMS is required by statute (section 1886(j)(2)(C)(ii) of the Act) to adjust payment rates for IRF services if we find evidence that changes in coding (that do not reflect real changes in case mix) have resulted or will result in changes in aggregate payments under the IRF classification system. As discussed in the proposed rule and above, CMS contracted

with RAND to examine changes in case mix and coding since the IRF PPS, using the most current available data. Using regression analysis of calendar year 2002 data, RAND found that payments to IRFs were about \$140 million more than expected during 2002 because of changes in the classification of patients in IRFs, and that a portion of this increase in payments was due to coding changes that do not reflect real changes in case mix. Specifically, RAND found that IRF payments were at least 1.9 percent higher because of changes in coding, based on direct indications of coding changes. Thus, we believe we have a responsibility to conform to the requirements of the statute and accordingly adjust payment rates for IRFs.

Second, analyses by RAND and by CMS's Office of the Actuary have both shown high Medicare margins among IRFs since implementation of the IRF PPS. RAND's analysis found that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. An analysis by CMS's Office of the Actuary supports these results. Given the evidence of high Medicare margins among IRFs, we believe that a 1.9 percent decrease in rates to account for coding changes will not affect beneficiary access to IRF services because IRFs will continue to be paid adequately to reflect the cost of resources needed to treat Medicare beneficiaries.

Furthermore, we continue to find evidence that enforcement of the 75 percent rule between July 2004 and July 2005 at the 50 percent compliance threshold did not have as large an impact on patients' access to IRF care as some industry analysts contend. At this time, CMS is finding no significant problems regarding access to care in IRFs; to the contrary, the trend is toward increasing utilization in all settings. For example, when we compared calendar years 2003 to 2004, we found that the number of IRF cases increased about 1.2 percent. We do not believe that beneficiary access to rehabilitation care will be unduly affected when IRFs have to meet a compliance threshold of 60 percent for cost reporting periods starting between July 1, 2005 and June 30, 2006. Based on the current available evidence, we do not believe that simultaneously reducing the standard payment amount by 1.9 percent to adjust for coding changes and phasing in enforcement of the 75 percent rule will have an undue effect on beneficiary access to IRF services. However, we will closely monitor the available data to ensure that beneficiaries' access to rehabilitation care is maintained.

Finally, we believe that the fact that 2002 was the year IRFs were transitioning to the IRF PPS further supports the finding that at least 1.9 percent of the payments in that year were due to coding changes and not to real changes in case mix. IRFs had not fully transitioned to the full Federal payment rates in 2002. Therefore, they were likely

only beginning to adjust to the new incentives of the IRF PPS and had only begun changing their coding practices. Had the full Federal payment rates for 2002 been fully implemented in 2002, then providers might have changed their coding practices even more than they did in 2002. Accordingly, RAND was likely only observing the initial provider responses to the new IRF PPS. Because RAND's estimate of the 1.9 percent is based on direct indication of coding changes that occurred in 2002, we believe that the 1.9 percent proposed reduction to the standard payment amount is appropriate at this time. In the future, we will examine later years of data in which providers were fully subject to the IRF PPS and make any necessary adjustments to the standard payment amount as we are required to do by statute to eliminate the effect on payments of coding or classification changes that do not reflect real changes in case mix.

Comment: A few commenters questioned RAND's assumption that characteristics of the patients recorded during the acute hospitalizations preceding the IRF stays are relevant for the condition of those same patients in the IRF stays.

Response: RAND's methodology in which they assumed that patient characteristics recorded during the acute hospitalizations preceding the IRF stays were relevant for the case mix of patients in the IRF stays produced a much higher estimate of the amount of coding change than we proposed to adopt in the FY 2006 proposed rule (70 FR 30188,

30221 though 30222). This methodology suggested a 5.8 percent reduction to the standard payment amount to account for coding change, as discussed above. As explained in the FY 2006 proposed rule (70 FR 30188, 30222), we used the estimate of the amount of coding change from RAND's second approach, which involved analyzing specific examples of coding that we know have changed over time, such as direct indications of improvements in impairment coding, changes in coding instructions for bladder and bowel functioning, and dramatic increases in coding of certain conditions that affect patients' placement into tiers (resulting in higher payments). This second approach produced the 1.9 percent estimate we proposed to use to adjust the standard payment amount.

Comment: One commenter requested that CMS conduct educational efforts for providers that instruct providers on how to code patients appropriately, rather than reducing the standard payment amount by 1.9 percent.

Response: As we discussed earlier in detail in this final rule under section VI.A, we proposed to reduce the standard payment amount by 1.9 percent to account for the effects of coding changes that occurred between 1999 and 2002 that resulted in higher than expected payments to IRFs, beginning in 2002. Section 1886(j)(2)(C)(ii) of the Act requires the Secretary to make such an adjustment to eliminate the effects of coding or classification changes that do not reflect real changes in case mix if the

Secretary determines that changes in coding or classification of patients have resulted or will result in changes in aggregate payments under the classification system. RAND's regression analysis of calendar year 2002 data found that payments to IRFs were about \$140 million more than expected during 2002 because of changes in the classification of patients in IRFs, and that a portion of this increase was due to coding changes that do not reflect real changes in case mix. Any provider education and training that CMS would conduct now would not revise RAND's finding that, based upon calendar year 2002 data, coding changes occurred that did not reflect real changes in case mix.

However, we agree with the commenter that provider education and training is important so that providers correctly code patients in IRFs. For this reason, CMS conducted extensive provider training in 2002 when the IRF PPS was first implemented, and we will continue to educate providers as to how to code the IRF-PAI items through our IRF-PAI coding help desk. We are open to considering other methods of provider education to encourage accurate provider coding. The primary resource providers should refer to is the IRF-PAI manual when they have questions regarding the correct way to code patients in IRFs. This manual is available on CMS's website at <http://www.cms.hhs.gov/providers/IRFPPS/IRFPAI-MANUAL040104.asp> and is updated regularly. The 1.9 percent

reduction adjustment to the standard payment amount is not intended to penalize providers for coding changes, but to reflect the statutory mandate to adjust IRF PPS payments when the Secretary determines that changes in coding or classification of patients have resulted or will result in changes in aggregate payments under the classification system.

Comment: One commenter questioned whether, in doing the analysis described above, RAND accounted for the 1.16 percent behavioral offset adjustment that CMS applied to the initial IRF PPS payment rates in the August 7, 2001 final rule (66 FR 41316).

Response: As explained in detail in RAND's report entitled "Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient Rehabilitation Facility Prospective Payment System" (available on RAND's website at <http://www.rand.org/publications/TR/TR213/>), RAND accounted for the 1.16 percent behavioral offset adjustment when they estimated the amount of observed case mix change that was due to real case mix change and the amount that was due to coding change. The range of estimates for the amount of case mix and coding change that RAND developed and that is reported above in this final rule contains an adjustment to account for this behavioral offset. If RAND had not taken account of the behavioral offset, their estimates of the amount of observed case mix change that was due to coding

change would have been larger than noted in both the FY 2006 proposed rule (70 FR 30188) and in this final rule.

Comment: One commenter suggested that the proposed 1.9 percent reduction of the standard payment amount could be implemented without undue hardship for facilities.

Response: We agree with the commenter. RAND estimates that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. This suggests that IRF payments are likely more than adequate to support this type of adjustment for coding changes.

Final Decision: After carefully considering all the comments we received on the proposed 1.9 percent reduction to the standard payment amount to adjust for coding changes between 1999 and 2002 that did not reflect real changes in case mix and resulted in increases in aggregate payments under the IRF classification system, we are finalizing our proposal to adopt the adjustment described above. In accordance with Section 1886(j)(2)(C)(ii) of the Act, and based on RAND's analysis of 2002 data compared with 1999 data, we believe this change is necessary to allow payment amounts to accurately reflect changes in IRFs' patient case mix (that is, the true cost of treating patients), and to ensure that they are not influenced by changes in coding practices.

We are finalizing our methodology for reducing the standard payment amount by 1.9 percent. First, we update the FY 2005 standard payment conversion factor by the estimated FY 2006 market basket of 3.6 percent (estimated for this final rule) to get the standard payment amount for FY 2006 ($\$12,958 * 1.036 = \$13,425$). Next, we multiply the FY 2006 standard payment amount by 0.981, which reduces the standard payment amount by 1.9 percent ($\$13,425 * 0.981 = \$13,169$). In section VI.B.7 of this final rule, we will further adjust the $\$13,169$ by the budget neutrality factors for the wage index and the other final changes outlined in this final rule that will result in the FY 2006 standard payment conversion factor. In section VI.B.7 of this final rule, we

provide a step-by-step calculation that results in the FY 2006 standard payment conversion factor.

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

1. Market Basket Used for IRF Market Basket Index

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

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

We are unable to create a separate market basket specifically for rehabilitation hospitals due to the small number of facilities and the limited data that are provided (for instance, only about 25 percent of rehabilitation facility cost reports reported contract labor cost data for 2002). Since all IRFs are paid under the IRF PPS, nearly

all LTCHs are paid under the LTCH PPS, and IPFs for cost reporting periods beginning on or after January 1, 2005 will be paid under the IPF PPS, in the FY 2006 proposed rule (70 FR 30188), we proposed and are finalizing to update payments for rehabilitation facilities using a market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs, hereafter referred to as the RPL (rehabilitation, psychiatric, long-term care) market basket.

As proposed and for this final rule, we are excluding children's and cancer hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in §413.40 of the regulations. They are not reimbursed under a prospective payment system. Also, the FY 2002 cost structures for children's and cancer hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. The services offered in IRFs, IPFs, and LTCHs are typically more labor-intensive than those offered in cancer and children's hospitals. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer and children's hospitals. In addition, the depreciation cost weights for IRFs, IPFs, and LTCHs are noticeably smaller than those for children's and cancer hospitals.

In the following discussion, we provide a background on market baskets and describe the methodologies we proposed

and are finalizing for purposes of determining the operating and capital portions of the FY 2002-based RPL market basket.

a. Overview of the RPL Market Basket

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

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

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

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

b. Methodology for Operating Portion of the RPL Market Basket

As proposed, the operating portion of the FY 2002-based RPL market basket, which is being adopted in this final rule, consists of several major cost categories derived from

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

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

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

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

The detailed cost categories under the residual (that is, the remaining portion of the market basket after excluding wages and salaries, drugs, and professional liability cost weights) are derived from the FY 2002-based IPPS market basket and the 1997 Benchmark Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. The FY 2002-based IPPS market basket is developed using FY 2002 Medicare hospital cost

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

Table 5 below sets forth the complete FY 2002-based RPL market basket including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 1997-based excluded hospital with capital market basket is listed as well.

As proposed and for this final rule, wages and salaries are 52.895 percent of total costs for the FY 2002-based RPL

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

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

Table 5 - FY 2002-based RPL Market Basket Cost Categories, Weights and Proxies With FY 1997-based Excluded Hospital With Capital Market Basket Used for Comparison

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	FY 2002-based RPL Market Basket	FY 2002 RPL Market Basket Price Proxies
TOTAL	100.000	100.000	
Compensation	57.579	65.877	-
Wages and Salaries*	47.335	52.895	EI-Wages and Salaries, Civilian Hospital Workers
Employee Benefits*	10.244	12.982	EI-Benefits, Civilian Hospital Workers
Professional fees Non-Medical*	4.423	2.892	EI - Compensation for Professional, Specialty & Technical Workers
Utilities	1.180	0.656	-
Electricity	0.726	0.351	PPI - Commercial Electric Power
Fuel Oil, Coal, etc.	0.248	0.108	PPI Refined Petroleum Products
Water and Sewage	0.206	0.197	CPI-U - Water & Sewage Maintenance
Professional Liability Insurance	0.733	1.161	CMS - Professional Liability Premium Index
All Other Products and Services	27.117	19.265	-

Expense Categories	FY 1997- based Excluded Hospital with Capital Market Basket	FY 2002-based RPL Market Basket	FY 2002 RPL Market Basket Price Proxies
All Other Prod. Products	17.914	13.323	-
Pharmaceuticals	6.318	5.103	PPI Prescription Drugs
Food: Direct Purchase	1.122	0.873	PPI Processed Foods & Feeds
Food: Contract Service	1.043	0.620	CPI-U Food Away From Home
Chemicals	2.133	1.100	PPI Industrial Chemicals
Blood and Blood Products**	0.748	--	
Medical Instruments	1.795	1.014	PPI Medical Instruments & Equipment
Photographic Supplies	0.167	0.096	PPI Photographic Supplies
Rubber and Plastics	1.366	1.052	PPI Rubber & Plastic Products
Paper Products	1.110	1.000	PPI Converted Paper & Paperboard Products
Apparel	0.478	0.207	PPI Apparel
Machinery and Equipment	0.852	0.297	PPI Machinery & Equipment
Miscellaneous Products	0.783	1.963	PPI Finished Goods less Food and Energy
All Other Services	9.203	5.942	-

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	FY 2002-based RPL Market Basket	FY 2002 RPL Market Basket Price Proxies
Telephone	0.348	0.240	CPI-U – Telephone Services
Postage	0.702	0.682	CPI-U – Postage
All Other: Labor Intensive*	4.453	2.219	ECI - Compensation for Private Service Occupations
All Other: Non-Labor Intensive	3.700	2.800	CPI-U All Items
Capital-Related Costs	8.968	10.149	-
Depreciation	5.586	6.186	-
Fixed Assets	3.503	4.250	Boeckh Institutional Construction: 23 year useful life
Movable Equipment	2.083	1.937	WPI – Machinery & Equipment: 11 year useful life
Interest Costs	2.682	2.775	-
Non-profit	2.280	2.081	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)--vintage weighted (23 years)
For-profit	0.402	0.694	Average yield on Moody's Aaa bonds--vintage weighted (23 years)

Expense Categories	FY 1997-based Excluded Hospital with Capital Market Basket	FY 2002-based RPL Market Basket	FY 2002 RPL Market Basket Price Proxies
Other Capital-Related Costs	0.699	1.187	CPI-U – Residential Rent

* Labor-related

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

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

Below we provide the proxies that we are using for the FY 2002-based RPL market basket in this final rule. We made no changes to the proposed price proxies in this final rule.

With the exception of the Professional Liability proxy, all the price proxies for the operating portion of the RPL market basket are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

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

- **Consumer Price Indexes--Consumer Price Indexes**

(CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we used CPIs only if an appropriate PPI was not available, or if the expenditures were more similar to those of retail consumers in general rather than purchases at the wholesale level. For example, the CPI for food purchased away from home is used as a proxy for contracted food services.

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

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

We note that the proxies are the same as those used for the FY 1997-based excluded hospital with capital market

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

Wages and Salaries

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

Employee Benefits

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

Nonmedical Professional Fees

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

Fuel, Oil, and Gasoline

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

Electricity

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

Water and Sewerage

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

Professional Liability Insurance

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

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

Pharmaceuticals

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

Food, Direct Purchases

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

Food, Contract Services

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

Chemicals

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

Medical Instruments

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

Photographic Supplies

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

Rubber and Plastics

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

Paper Products

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

Apparel

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

Machinery and Equipment

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

Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) is applied to this component. Using this index removes the double-counting of food and energy prices, which are captured elsewhere in the market basket. The weight for this cost category is higher than in the 1997-based index because the weight for food and food products

(1.322) is added to it. In the 1997-based excluded hospital with capital market basket we included a separate cost category for blood and blood products, using the BLS Producer Price Index for blood and derivatives as a price proxy. A review of recent trends in the PPI for blood and derivatives suggests that its movements may not be consistent with the trends in blood costs faced by hospitals. While this proxy did not match exactly with the product hospitals are buying, its trend over time appears to be reflective of the historical price changes of blood purchased by hospitals. However, an apparent divergence in trends in the PPI for blood and derivatives and trends in blood costs faced by hospitals over recent years led us to reevaluate whether the PPI for blood and derivatives was an appropriate measure of the changing price of blood. As discussed in the FY 2006 proposed rule (70 FR 30188), we ran test market baskets classifying blood in 3 separate cost categories: blood and blood products, contained within chemicals as was done for the 1992-based excluded hospital with capital market basket, and within miscellaneous products. These categories use as proxies the following PPIs: the PPI for blood and blood products, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three proxies, the PPI for finished goods less food and energy moved most like the recent blood cost and price trends. In addition, the impact on the overall market basket by using different proxies for

blood was negligible, mostly due to the relatively small weight for blood in the market basket.

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

Telephone

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

Postage

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

All Other Services, Labor Intensive

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

All Other Services, Nonlabor Intensive

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

c. Methodology for Capital Portion of the RPL Market Basket

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

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

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

on the common assumption that overhead is 10 percent of costs. The remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

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

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

As proposed, for this final rule we derived the split using the relative FY 2001 Medicare cost report data for IPPS hospitals on interest expenses for the government/nonprofit and for-profit hospitals. Due to insufficient Medicare cost report data for IRFs, IPFs and LTCHs, as proposed and for this final rule, we used the same split used in the IPPS capital input price index, which is

75-25. We believe it is important that this split reflects the latest relative cost structure of interest expenses for hospitals. Therefore, as proposed in the FY 2006 proposed rule (70 FR 30188) we are using a 75-25 split to allocate interest expenses to government/nonprofit and for-profit. See the IPPS Rule for FY 2006, Section IV.D, Capital Input Price Index Section (70 FR 23406).

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

Vintage weights are an integral part of the FY 2002-based RPL market basket. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same

period it is purchased. The capital portion of the FY 2002-based RPL market basket reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes.

Annual non-vintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes for Medicare capital-related costs. The capital component of the FY 2002-based RPL market basket reflects the underlying stability of the capital acquisition process and provide hospitals with the ability to plan for changes in capital payments.

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

expenses were calculated by multiplying the AHA Annual Survey total hospital expenses by the ratio of depreciation to total hospital expenses from the Medicare cost reports. Beginning in 2001, the AHA Annual survey began collecting depreciation expenses. We hope to be able to use this data in any future rebasings.

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

Between the publication of the June 24, 2005 proposed

rule and this final rule, we conducted a further review of the methodology used to derive the useful life of an asset.

Based on this brief analysis into the capital cost structures of hospitals, we are not changing the expected life of fixed and moveable assets for the final rule.

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

As proposed, for this final rule, for building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation.

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

As proposed, for this final rule, for movable equipment vintage weights, the real annual capital purchase amounts

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

As proposed, for this final rule, for interest vintage

weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel and Annual Surveys were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Since hospital debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods. With nominal total equipment purchase estimates available back to 1963, sixteen 23-year periods are averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the sixteen 23-year periods. The average of the sixteen 23-year periods is used to determine the FY 2002 average interest vintage weights. The vintage weights for the index are presented in Table 6 below.

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

**TABLE 6.—CMS FY 2002-based RPL Market Basket Capital
Vintage Weights**

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

The final FY 2006 update for IRF PPS using the FY 2002-based RPL market basket is 3.6 percent. This is based on Global Insight's 2nd quarter 2005 forecast, incorporating two more quarters of historical data than published in the FY 2006 IRF proposed rule. This includes increases in both the operating section and the capital section. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. Using the current FY 1997-based excluded hospital with capital market basket (66 FR at 41427), Global Insight's second quarter 2005 forecast for FY 2006 is also 3.6 percent. Table 7 below compares the FY 2002-based RPL market basket and the FY 1997-based excluded hospital with capital market basket percent changes. For both the historical and forecasted periods between FY 2000 and FY 2008, the difference between the two market baskets is minor with the exception of FY 2002 where the FY 2002-based RPL market basket increased three tenths of a percentage point higher than the FY 1997-based excluded hospital with capital market basket. This is primarily due to the FY 2002-based RPL market basket having a larger compensation (that is, the sum of wages and salaries and benefits) cost weight than the FY 1997-based index and the price changes associated with compensation costs increasing much faster than the prices of other market basket components. Also contributing is the all other nonlabor intensive cost weight, which is smaller in the FY

2002-based RPL market basket than in the FY 1997-based index, and the slower price changes associated with these costs.

TABLE 7: FY 2002-based RPL Market Basket and FY 1997-based Excluded Hospital with Capital Market Basket Percent Changes, FY 2000 - FY 2008

Fiscal Year (FY)	Rebased FY 2002-based RPL Market Basket	FY 1997-based Excluded Hospital Market Basket with Capital
Historical data:		
FY 2000	3.1	3.1
FY 2001	4.0	4.0
FY 2002	3.9	3.6
FY 2003	3.8	3.7
FY 2004	3.6	3.7
Average FYs 2000-2004	3.7	3.6
Forecast:		
FY 2005	3.8	3.9
FY 2006	3.6	3.6
FY 2007	3.2	3.1
FY 2008	3.1	2.9
Average FYs 2005-2008	3.4	3.4

Source: Global Insight, Inc. 2nd Qtr 2005, @USMACRO/CNTL0605 @CISSIM/TL0505.SIM

Comment: One commenter recommended that the current update be increased to reflect the differences between the updates given in FY 2004 and FY 2005 and the final market basket increases. Another commenter recommended that CMS adopt a forecast error adjustment.

Response: There is currently no mechanism for

adjusting for forecast error in the IRF PPS. Also, the FY 2005 updates is not based on historical data. The forecast error for FY 2005 will not be available until we publish the 2005q4 forecast (with historical data through 2005q3) version of the market basket. We have been actively working with our contractor to minimize forecast error. The specific details of our analysis are provided in the response to following comment.

Comment: Several commenters requested that CMS review and revise the methodology used to forecast the FY 2006 market basket. They are concerned that the proposed FY 2006 update of 3.1 percent is a dramatic underestimation. One commenter requested that CMS make the calculation of the projected FY 2006 available to the public.

Response: Before we published the FY 2006 proposed rule, we had been actively working with our forecasting firm, Global Insight, Inc. (GII), to improve the forecasting accuracy of the market baskets. GII is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. Among other services GII provides to CMS, GII calculates projected inflation factors for price proxies using models that take into account sectoral, national, and global economic trends.

Over the last several years, dramatic fluctuations in the price of certain costs have made it difficult to forecast price proxy inflation. The driving force behind a

significant portion of this uncertainty has been the instability of energy costs. With our input and consultation, however, GII recently re-evaluated and modified their forecasting models to help improve their forecasting accuracy. Using these improved forecasting models, GII calculated updated inflation factors for the major cost categories in Table 8.

Table 8 - Comparison of the 4 Quarter Moving Average Percent Changes for Several Cost Category Weights between the FY 2006 Proposed and Final Rules.

Expense Category	FY 2002-based Cost weights	GII 2004q4 forecast of FY 2006 (Proposed Rule)	GII 2005q2 forecast of FY 2006 (Final Rule)
Total - RPL02	100.00	3.1	3.6
Compensation	65.877	3.5	3.9
Utilities	0.656	0.8	3.6
Professional Fees	2.892	3.6	3.8
Professional Liability Insurance	1.161	8.4	5.2
All Other	19.265	2.5	3.2
All Other			
Products	13.323	2.6	3.5
All Other			
Services	5.942	2.4	2.6
Capital	10.149	0.9	1.1

d. Labor-Related Share

Section 1886(j)(6) of the Act specifies that the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the

relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

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

The labor-related share for FY 2006 is the sum of the FY 2006 relative importance of each labor-related cost

category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and FY 2006. For this final rule, we are revising the labor-related share to reflect Global Insight's second quarter 2005 forecast, incorporating two more quarters of historical data than published in the FY 2006 IRF proposed rule. Thus, for this final rule, the sum of the relative importance for FY 2006 for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 71.708 percent, as shown in the chart below. The portion of capital that is influenced by local labor markets is estimated to be 46 percent, which is the same percentage currently used in the IRF prospective payment system. Since the relative importance for capital is 9.037 percent of the FY 2002-based RPL market basket in FY 2006, we took 46 percent of 9.037 percent to determine the capital labor-related share for FY 2006. The result is 4.157 percent, which we add to 71.708 percent for the operating cost amount to determine the total labor-related share for FY 2006. Thus, the labor-related share that we are using for IRF PPS in FY 2006 is 75.865 percent. This labor-related share is determined using the same methodology as employed in calculating all previous IRF labor-related shares (66 FR at 41357).

Table 9 below shows the final FY 2006 relative importance labor-related share using the 2002-based RPL

market basket and the labor-related share using the FY 1997-based excluded hospital with capital market.

Table 9 - Total Labor-Related Share

Cost Category	FY 2002-based RPL Market Basket Relative Importance (Percent) FY 2006	FY 1997 Excluded Hospital with Capital Market Basket Relative Importance (Percent) FY 2006
Wages and salaries	52.592	48.185
Employee benefits	14.028	11.542
Professional fees	2.921	4.558
All other labor intensive services	2.167	4.450
SUBTOTAL	71.708	68.735
Labor-related share of capital costs	4.157	3.289
TOTAL	75.865	72.024

Public comments that we received are summarized below.

Comment: Several commenters objected to our proposal to change the labor-related share to 75.958 percent. One commenter suggested CMS maintain the FY 2005 labor-related share of 72.359 percent until CMS can develop an IRF-specific wage index. Another commenter stated there is no precedent to change the labor-related share. Another commenter requested that if CMS implemented a change in the LRS, they request a transition where the transitional labor-related share would be composed of 80 percent of the current labor-related share and 20 percent of the proposed labor-related share.

Response: Identical to previous updates, the labor-related share is calculated as the sum of the relative

importance of those costs that are related to, influenced by, or vary with the local labor market. Specifically, the FY 2006 labor related share is equal to the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from the RPL market basket.

We calculate the labor-related relative importance for FY 2006 in four steps. First, we compute the FY 2006 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2006 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2006 relative importance for each cost category by multiplying this ratio by the base year (FY 2002) weight. Finally, we sum the FY 2006 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, nonmedical professional fees, labor-intensive services, and capital-related expenses) to produce the FY 2006 labor-related relative importance.

The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2006 when compared to the base year weights from the RPL market basket. Thus, the LRS has been and should be revised with

each fiscal year update.

CMS disagrees with the commenter's suggestion to transition from the FY 2005 to the FY 2006 labor-related share. We note the FY 2006 labor-related share is based on the same methodology used to calculate the FY 2005 labor-related share (that is, it is composed of the costs that are related to, influenced by, or vary with the local labor market). Furthermore, the FY 2006 labor-related share is based on the 2002-based RPL market basket, which we believe adequately reflects the current cost structures of Medicare-participating IRFs. Therefore, we do not believe a transition is necessary.

Comment: Several commenters suggested that we include professional liability insurance (PLI) in the labor-related share since these costs are included in the wage index. The commenters also claim that professional liability insurance costs are wage-related.

Response: The wage index includes, as a fringe benefit cost, PLI for those policies that list actual names or specific titles of covered employees (59 FR 45358). The benefit cost weight in the market basket, included in the labor-related share, is also based on the same wage index benefit data. Therefore, the labor-related share includes these PLI costs. General PLI coverage maintained by hospitals is not recognized as a wage-related cost for purposes of the wage index or labor-related share.

Although general PLI costs do vary by geographic

region, this variance is primarily influenced by state legislation and risk level, not by local wage rates. In fact, areas with high wage indices may have low relative PLI costs. For example, the malpractice geographic price indices, used in the Medicare physician payment system, for San Francisco, Los Angeles, and Boston regions are below 1, while their hospital wage indices for comparable areas are much greater than 1.

Comment: Several commenters recommended CMS delay the implementation of the RPL market basket until CMS has reviewed the accuracy of the cost report data. Specifically, they requested CMS investigate HealthSouth's claim to have omitted home office and some depreciation costs from their 2002 and 2003 Medicare cost reports.

Response: The FY 2006 market basket update is based on the RPL market basket using FY 2002 Medicare cost report data. CMS has determined that, in the absence of FY 2002 HealthSouth home office cost report data, we will not incorporate preliminary FY 2004 HealthSouth home office costs into the 2002-based RPL market basket. (Due to a change in Medicare cost report requirements beginning with FY 2002, we used FY 2001 capital costs aged to FY 2002 in the 2002-based RPL market basket. Therefore, HealthSouth's depreciation costs were included in the RPL market basket and reflected in the FY 2006 market basket update.)

Home office costs represent only one of many cost categories (including but not limited to salaries, benefits,

professional liability insurance, and pharmaceuticals) that are used to develop the cost category weights. We believe the absence of HealthSouth home office costs in this market basket has a minor impact on the distribution of these weights and, by extension, the final market basket update itself. When CMS receives full FY 2004 Medicare cost report data from HealthSouth, we plan to re-evaluate this decision.

Final Decision: We are finalizing our decision to update payments for rehabilitation facilities using the RPL market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs.

2. Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs that are attributable to wages and wage-related costs by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. Not later than October 1, 2001 and at least every 36 months thereafter, the Secretary is required to update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under section

1886(j) (6) of the Act for a FY shall be made in a manner that assures the aggregated payments under section 1886(j) (6) of the Act are not greater or less than those that will have been made in the year without such adjustment.

In our August 1, 2003 final rule (68 FR 45674), we acknowledged that on June 6, 2003, the Office of Management and Budget (OMB) issued "OMB Bulletin No.03-04," announcing revised definitions of Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the Bulletin may be obtained at the following Internet address:

<http://www.whitehouse.gov/omb/bulletins/b03-04.html>. At that time, we did not propose to apply these new definitions known as the Core-Based Statistical Areas (CBSAs). After further analysis and discussed in detail in section VI.B.2.d, we proposed to revised labor market area definitions as a result of the OMB revised definitions to adjust the FY 2006 IRF PPS payment rate. In addition, the IPPS is applying these revised definitions as discussed in the August 11, 2004 final rule (69 FR at 49207). We will adopt the CBSA-based geographic classifications as proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188) and described below in section VI.B.2.d and section VI.B.2.e.

a. Revisions to the IRF PPS Geographic Classification

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

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

In the FY 2006 IRF PPS proposed rule (70 FR 30188, 30235), we described the labor markets that have been used for area wage adjustments under the IRF PPS since its implementation of cost reporting periods beginning on or after January 1, 2002. Previously, we have not described

the labor market areas used under the IRF PPS in detail. However, we published each area's wage index in the IRF PPS final rules and update notices, each year and noted the use of the geographic area in applying the wage index adjustment in the IRF PPS payment examples in the final regulation implementing the IRF PPS (69 FR 41316, 41367 through 41368).

The IRF industry has also understood that the same labor market areas in use under the IPPS (from the time the IRF PPS was implemented, for cost reporting periods beginning on or after January 1, 2002) are used under the IRF PPS. The OMB adopted new statistical area definitions (70 FR 30188, 30235-30238) and we proposed to adopt the new labor market area definitions based on these areas under the IRF PPS. Therefore, we are providing a more detailed description of the current IRF PPS labor market areas in this final rule, in order for the public to better understand the change to the IRF PPS labor market areas.

The current IRF PPS labor market areas are defined based on the definitions of MSAs, Primary MSAs (PMSAs), and NECMAs issued by the OMB (commonly referred to collectively as "MSAs"). These MSA definitions are used before October 1, 2005, under the IRF PPS and other prospective payment systems, such as LTCH, IPF, Home Health Agency (HHA), and SNF (Skilled Nursing Facility) PPSs. In the IPPS final rule (67 FR at 49026 through 49034), revised labor

market area definitions were adopted under the hospital IPPS (§412.64(b)), which are effective October 1, 2004 for acute care hospitals. These new CBSA standards were announced by the OMB late in 2000.

b. Current IRF PPS Labor Market Areas Based on MSAs

As mentioned earlier, since the implementation of the IRF PPS in the August 7, 2001 IRF PPS final rule, we used labor market areas to further characterize urban and rural areas as determined under §412.602 and further defined in §412.62(f)(1)(ii) and (f)(1)(iii) for discharges before October 1, 2005. We defined labor market areas under the IRF PPS based on the definitions of MSAs, PMSAs, and NECMAs issued by the OMB, which is consistent with the IPPS approach. The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of 1 million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs (as described in section VI.B.2.d.ii of this final rule). If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

These different designations use counties as the building blocks upon which they are based. Therefore, IRFs are assigned to either an MSA, PMSA, or NECMA based on

whether the county in which the IRF is located is part of that area. All of the counties in a State outside a designated MSA, PMSA, or NECMA are designated as rural. For the purposes of calculating the wage index, we combine all of the counties in a State outside a designated MSA, PMSA, or NECMA together to calculate the statewide rural wage index for each State.

c. Core-Based Statistical Areas (CBSAs)

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

In the December 27, 2000 **Federal Register** (65 FR at 82228 through 82238), OMB announced its new standards. In that notice, OMB defines CBSA, beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the

core as measured by commuting ties." The standards designate and define two categories of CBSAs: MSAs and **Micropolitan** Statistical Areas (65 FR at 82235 through 82238).

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

<http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html>.)

The new CBSA designations recognize 49 new MSAs and 565 new **Micropolitan** Areas, and revise the composition of many of the existing MSAs. There are 1,090 counties in MSAs under the new CBSA designations (previously, there were 848 counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were prior to the change in designations, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in

Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer designated to either an MSA or a new Micropolitan Area: Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA. For a more detailed discussion of the conceptual basis of the new CBSAs, refer to the IPPS final rule (67 FR at 49026 through 49034).

d. Revisions to the IRF PPS Labor Market Areas

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

We currently use MSAs to define labor market areas for purposes of the wage index. In fact, MSAs are also used to define labor market areas for purposes of the wage index for many of the other Medicare prospective payment systems (for example, LTCH, SNF, HHA, IPF, and Outpatient). While we recognize MSAs are not designed specifically to define labor market areas, we believe they represent a reasonable and

appropriate proxy for this purpose, because they are based upon characteristics we believe also generally reflect the characteristics of unified labor market areas. For example, CBSAs reflect a core population plus an adjacent territory that reflects a high degree of social and economic integration. This integration is measured by commuting ties, thus demonstrating that these areas may draw workers from the same general areas. In addition, the most recent CBSAs reflect the most up-to-date information. The OMB reviews its Metropolitan Area (MA) definitions preceding each decennial census to reflect recent population changes and the CBSAs are based on the Census 2000 data. Thus, we proposed to adopt the new CBSA designations to define labor market areas for the purposes of the IRF PPS.

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

based on the OMB's CBSA designations.

As specified in §412.624(e)(1), we explained in the August 7, 2001 final rule that the IRF PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Since OMB's CBSA designations are based on Census 2000 data and reflect the most recent available geographic classifications, we will adopt the labor market area definitions used under the IRF PPS as proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188). Specifically, we will revise the IRF PPS labor market definitions based on the OMB's new CBSA designations effective for IRF PPS discharges occurring on or after October 1, 2005.

Accordingly, we will revise §412.602 to specify that for discharges occurring on or after October 1, 2005, the application of the wage index under the IRF PPS will be made on the basis of the location of the facility in an urban or rural area as defined in §412.64(b)(1)(ii)(A) through (C) as proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188).

(As a conforming change, we will revise §412.602, definitions for rural and urban areas effective for discharges occurring on or after October 1, 2005 will be defined in §412.64(b)(1)(ii)(A) through (C) as proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188) and adopted

in this final rule. In addition (as proposed in the FY 2006 IRF PPS proposed rule at 70 FR 30188), we will revise the regulation text to explicitly reference urban and rural definitions for a cost-reporting period beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005 under §412.62(f)(1)(ii) and §412.62(f)(1)(iii).

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

policy after IPPS policy.

In sections VI.B.2.d.i. through VI.B.2.d.iii of this final rule and as described in the FY 2006 IRF PPS proposed rule (70 FR 30188), we describe the composition of the IRF PPS labor market areas based on the OMB's new CBSA designations.

i. New England MSAs

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

To create consistency among all labor market areas and to maintain these areas on the basis of counties, we proposed to and are adopting in this final rule to use the county-based areas for all MSAs in the nation, including those in New England. Census has now defined the New England area based on counties, creating a city- and

town-based system as an alternative. We believe that adopting county-based labor market areas for the entire country except those in New England will lead to inconsistencies in our designations. Adopting county-based labor market areas for the entire country provides consistency and stability in the Medicare payment program because all the labor market areas throughout the country, including New England, will be defined using the same system (that is, counties) rather than different systems in different areas of the country, and minimizes programmatic complexity.

We have consistently employed a county-based system for New England for precisely that reason: to maintain consistency with the labor market area definitions used throughout the country. Because we have never used cities and towns for defining IRF labor market areas, employing a county-based system in New England maintains that consistent practice. We note that this is consistent with the implementation of the CBSA-based designations under the IPPS for New England (see 69 FR at 49028). Accordingly, as specified in the FY 2006 proposed rule (70 FR 30188), we are using the New England MSAs as determined under the new CBSA-based labor market area definitions in defining the revised IRF PPS labor market areas in this final rule.

ii. Metropolitan Divisions

Under OMB's new CBSA designations, a Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties. A county qualifies as a main county if 65 percent or more of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75.

A county qualifies as a secondary county if 50 percent or more, but less than 65 percent, of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75. After all the main and secondary counties are identified and grouped, each additional county that already has qualified for inclusion in the MSA falls within the Metropolitan Division associated with the main/secondary county or counties with which the county at issue has the highest employment interchange measure. Counties in a Metropolitan Division must be contiguous (65 FR at 82236).

The construct of relatively large MSAs being comprised of Metropolitan Divisions is similar to the current construct of the CMSAs comprised of PMSAs. As noted above, in the past, OMB designated CMSAs as Metropolitan Areas with a population of 1 million or more and comprised of two or

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

CBSA-based labor market area definitions.

In addition to being comparable to the organization of the labor market areas under the current MSA designations (that is, the use of PMSAs rather than CMSAs), we believe that using Metropolitan Divisions where applicable (as described below) under the IRF PPS will result in a more accurate adjustment for the variation in local labor market areas for IRFs. Specifically, if we were to recognize the relatively "larger" CBSA that comprises two or more Metropolitan Divisions as an independent labor market area for purposes of the wage index, it will be too large and will include the data from too many hospitals to compute a wage index that will accurately reflect the various local labor costs of all the individual hospitals included in that relatively "large" CBSA.

As mentioned earlier, a large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that will be relevant for all hospitals within the market area designation. Rather, by recognizing Metropolitan Divisions where applicable (as described below) under the new CBSA-based labor market area definitions under the IRF PPS, we believe that in addition to more accurately

maintaining the current structuring of the IRF PPS labor market areas, the local labor costs will be more accurately reflected, thereby resulting in a wage index adjustment that better reflects the variation in the local labor costs of the local economies of the IRFs located in these relatively "smaller" areas. In section VI.B.2.d.ii. of this final rule, we describe where Metropolitan Divisions will be applicable under the new CBSA-based labor market area definitions under the IRF PPS final rule.

Under the OMB's CBSA-based designations, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. Although these MSAs were also CMSAs under the prior definitions, in some cases their areas have been altered. Under the current IRF PPS MSA designations, Boston is a single NECMA. Under the CBSA-based labor market area designations, it is comprised of four Metropolitan Divisions. Los Angeles will go from four PMSAs under the current IRF PPS MSA designations to two Metropolitan Divisions under the CBSA-based labor market area designations. The New York CMSA will go from 15 PMSAs under the current IRF PPS MSA designations to four Metropolitan Divisions under the CBSA-based labor market area designations. The five PMSAs in Connecticut under the current IRF PPS MSA designations will become

separate MSAs under the CBSA-based labor market area designations because two MSAs became separate MSAs. The number of PMSAs in New Jersey, under the current IRF PPS MSA designations will go from five to two, with the consolidation of two New Jersey PMSAs (Bergen-Passaic and Jersey City) into the New York-Wayne-White Plains, NY-NJ Division, under the CBSA-based labor market area designations. In San Francisco, under the CBSA-based labor market area designations there are only two Metropolitan Divisions. Currently, there are six PMSAs, some of which are now separate MSAs under the current IRF PPS labor market area designations.

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

We note that subsequent to the publication of the

FY 2006 IRF PPS proposed rule (70 FR 30188), titles to certain CBSAs were changed based on OMB Bulletin No. 05-02 (November 2004). The title changes listed below are nomenclatures that do not result in substantive changes to the CBSA-based designations. Thus, these changes are listed below and will be incorporated into the FY 2007 CBSA-based urban wage index tables.

- CBSA 36740: Orlando-Kissimmee, FL
- CBSA 37620: Parkersburg-Marietta-Vienna, WV-OH
- CBSA 42060: Santa Barbara-Santa Monica, CA
- CBSA 13644: Bethesda-Gaithersburg-Frederick, MD
- CBSA 32580: McAllen-Edinburg-Mission, TX
- CBSA 26420: Huston-Sugar Land-Baytown, TX
- CBSA 35644: New York-White Plains-Wayne, NY-NJ

ii. Micropolitan Areas

Under the new OMB CBSA-based designations, Micropolitan Areas are essentially a third area definition consisting primarily of areas that are currently rural, but also include some or all of areas that are currently designated as urban MSA. As discussed in greater detail in the IPPS final rule (69 FR at 49029 through 49032), how these areas are treated will have significant impacts on the calculation and application of the wage index. Specifically, whether or not Micropolitan Areas are included as part of the respective statewide rural wage indices will impact the

value of the statewide rural wage index of any State that contains a Micropolitan Area because a hospital's classification as urban or rural affects which hospitals' wage data are included in the statewide rural wage index. As discussed above in section VI.B.2.b of this final rule, we combine all of the counties in a State outside a designated urban area to calculate the statewide rural wage index for each State.

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

Since the implementation of the IRF PPS, we used MSAs to define urban labor market areas and group all the hospitals in counties within each State that are not assigned to an MSA into a statewide rural labor market area.

Therefore, we used the terms "urban" and "rural" wage indices in the past for ease of reference. However, the introduction of Micropolitan Areas by the OMB potentially

complicates this terminology because these areas include many hospitals that are currently included in the statewide rural labor market areas.

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

In the IPPS final rule (69 FR at 49029 through 49032), we discuss our evaluation of the impact of treating Micropolitan areas as part of the statewide rural labor market area instead of treating Micropolitan Areas as independent labor market areas for hospitals paid under the IPPS. As an alternative to treating Micropolitan Areas as part of the statewide rural labor market area for purposes of the IRF PPS, in the FY 2006 proposed rule (70 FR 30188), we examined treating Micropolitan Areas as separate (urban) labor market areas, just as we did when implementing the revised labor market areas under the IPPS.

As discussed in greater detail in that same final rule, the designation of Micropolitan Areas as separate urban areas for wage index purposes will have a dramatic impact on the calculation of the wage index. This is because Micropolitan areas encompass smaller populations than MSAs, and tend to include fewer hospitals per Micropolitan area. Currently, there are only 25 MSAs with one hospital in the MSA. However, under the new CBSA-based definitions, there are 373 Micropolitan Areas with one hospital, and 49 MSAs with only one hospital.

Since Micropolitan Areas encompass smaller populations than MSAs, they tend to include fewer hospitals per Micropolitan Area, recognizing Micropolitan Areas as independent labor market areas will generally increase the potential for dramatic shifts in those areas' wage indices from one year to the next because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of the area. The large number of labor market areas with only one hospital and the increased potential for dramatic shifts in the wage indexes from one year to the next is a problem for several reasons. First, it creates instability in the wage index from year to year for a large number of hospitals. Second, it reduces the averaging effect (this averaging effect allows for more data points to be used to calculate the representative standard

of measured labor costs within a market area) lessening some of the incentive for hospitals to operate efficiently. This incentive is inherent in a system based on the average hourly wages for a large number of hospitals, as hospitals could profit more by operating below that average. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. Third, it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals. Therefore, in order to minimize the potential instability in payment levels from year to year, we believe it will be appropriate to treat Micropolitan Areas as part of the statewide rural labor market area under the IRF PPS.

For the reasons noted above, and consistent with the treatment of these areas under the IPPS, we proposed and are adopting Micropolitan Areas as independent labor market areas under the IRF PPS. Under the new CBSA-based labor market area definitions, Micropolitan Areas are considered a part of the statewide rural labor market area. Accordingly, we will determine an IRF PPS statewide rural wage index using the acute-care IPPS hospital wage data (the rationale for using IPPS hospital wage data is discussed in

section III.B.2.f of this final rule) from hospitals located in non-MSA areas assign the statewide rural wage index to IRFs located in those areas.

e. Implementation of the CBSA-based Labor Market Areas

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

In the FY 2006 IRF PPS proposed rule (70 FR 30188), Table 3 listed IRFs that submitted an IRF-PAI in the past 18-months. The data in Table 3 was obtained from a report we requested in February 2005 from the Iowa Foundation for Medical Care (IFMC). IFMC is the CMS contractor where the IRF-PAI database is located. Table 3 listed each IRF's provider number; provider name; and State and county location; existing MSA-based labor market area designation; and its CBSA-based designation. The purpose of Table 3 was to only facilitate an understanding of the policies related

to the proposed change to the IRF PPS labor market areas discussed above by illustrating an IRF's change from the MSA-based designation to the proposed CBSA-based designation. Thus, FIs will not be instructed to use Table 3 in the FY 2006 IRF PPS proposed rule (70 FR 30188) to alter the information regarding an IRF's State and county location or to make changes to the provider specific file based on Table 3 of the FY 2006 IRF PPS proposed rule.

Table 1 of the addendum of this final rule is a crosswalk file of all counties/areas in the United States, Guam, Puerto Rico, and the Virgin Islands with the corresponding State and county code, county and State name, FY 2006 MSA number, FY 2006 MSA-based urban or rural designation, FY 2006 MSA-based wage index, FY 2006 CBSA-based wage index, FY 2006 CBSA number, FY 2006 CBSA-based urban or rural designation, and FY 2006 blended one-year transition wage index as discussed below in Section VI.B.2.e. Table 1 of the addendum to this final rule will be used by FIs to determine the FY 2006 one-year transition wage index for IRFs located in areas as documented in the FI's provider specific file.

When the revised labor market areas based on OMB's new CBSA-based designations were adopted under the IPPS beginning on October 1, 2004, a transition to the new designations was established due to the scope and

substantial implications of these new CBSA-based designations in order to buffer the subsequent substantial impacts on numerous hospitals. As discussed in the IPPS final rule (69 FR at 49032), during FY 2005, a blend of wage indices is calculated for those acute care IPPS hospitals experiencing a drop in their wage index because of the adoption of the new labor market areas. The most substantial decrease in wage index impacts urban acute-care hospitals that were designated as rural under the CBSA-based designations.

In the FY 2006 IRF PPS proposed rule (70 FR 30188), we recognize that, just like IPPS hospitals, IRFs may experience decreases in their wage index as a result of the labor market area changes. Our data analysis for the FY 2006 IRF PPS proposed rule (70 FR 30188) indicated that a majority of IRFs either expect no change in wage index or an increase in wage index based on CBSA definitions. Based on this analysis for the FY 2006 IRF PPS proposed rule (70 FR 30188), we found a very small number of IRFs (3 percent) will experience a decline of 5 percent or more in the wage index based on CBSA designations. A 5 percent decrease in the wage index for an IRF may result in a noticeable decrease in their wage index compared to what their wage index would have been for FY 2006 under the MSA-based designations. We also found that a very small number of IRFs (4 percent) would experience a change in either rural

or urban designation under the CBSA-based definitions. Since a majority of IRFs would not be significantly impacted by the labor market areas, we did not propose a transition to the new CBSA-based labor market area, nor did we propose to adopt a hold harmless policy, nor an "out-commuting" policy for the purposes of the IRF PPS wage index.

Public comments and our responses on the proposed changes for implementing the area wage adjustments are summarized below:

Comment: A large number of commenters urged CMS to develop a transition policy or implement a similar transition policy as was implemented under the IPPS to minimize the fiscal impact of the change in wage index. Many advocated for a one-year transition with a blended wage index, equal to 50 percent of the FY 2006 MSA wage index and 50 percent of the FY 2006 CBSA-based wage index. We also received a few comments recommending a multi-year transition and possibly a permanent blended wage index. Overall, commenters expressed concerns for IRFs that would experience a significant decrease in the wage index. In general, commenters request that we mitigate the impact of the change from the MSA-based designation to the CBSA-based designations over time with a transition policy.

Response: We recognize that some IRFs will experience decreases in their applicable wage index as a result of the

conversion from the MSA-based designations to the CBSA-based designations. After further analysis of various transition options suggested by commenters as well as our further data analysis to support the policies in this final rule, we considered various transition options to determine a transition policy that would mitigate the impact on IRFs that would experience a decrease in the wage index, and buffer the overall impact on the unadjusted payment rate. Based on the commenters' recommendations, we carefully reviewed various budget neutral transition policies such as a blended wage index as well as a floor and ceiling approach as discussed in detail below.

We reviewed a floor and ceiling transition policy option. Although this option seemed to minimize the impact on IRFs, we found that this approach would provide relief to IRFs that experience a decrease in the wage index, but with respect to IRFs that would get a significant increase in the wage index, it would also limit the amount they could expect their wage index to increase. The difficulty of developing a floor and ceiling transition policy is determining an appropriate floor and a ceiling that would best mitigate IRFs that experience a decrease in the wage index while lessening the overall impact on the unadjusted base payment kept us from choosing this option.

Although a few commenters recommended a permanent

blended wage index (comprised of the MSA-based wage index and the CBSA-based wage index), we do not believe this is appropriate. Beginning in FY 2006, acute care hospital will receive 100 percent of the IPPS wage index based on the new CBSA wage index. From FY 2006 and forward, CMS will no longer maintain the geographic classifications based on MSAs. Therefore, MSA-based wage indexes will not be able to reflect the same amount of accuracy as they currently represent by having the geographical classification updated annually. By developing a permanent blended wage index, CMS would only be geographically updating the CBSA-based areas and not the MSA-based areas. Consequently, we believe that implementation of a permanent blended wage index would result in a wage index that is not as accurate as a wage index based on the CBSA methodology, as thoroughly discussed in section VI.B.2.d.

Several commenters suggested that IRFs be afforded the same transition as adopted by IPPS (69 FR 48916, 49032 - 49034). Therefore, another budget neutral one-year transition policy we considered would blend the wage index for IRFs that would experience a reduction in the wage index. The blended wage index would consist of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both based on the FY 2001 hospital wage data), only for IRFs that experience a

decrease due solely to the changes in the labor market definitions. Although some commenters recommended this transition policy, we believe that this would not allow all IRFs the ability to transition from the MSA-based wage index to the CBSA-based wage index because this transition policy only focuses on the blending the wage index for IRFs that experience a decrease in the wage index. In addition, we found that this would change the budget neutrality factor applied to the base rates from 0.9996 if there was no transition to 0.9977 under this transition policy. Therefore, the budget neutrality factor under the transition policy for only those IRFs that experience a decrease in the wage index would reduce the unadjusted base rate by approximately more than 20 dollars. The overall impact based on the reduction of the unadjusted base rate would result in all IRFs experiencing a reduction in payments. Under this approach, we found that IRFs would experience a significant reduction in the unadjusted payment amount, which would not mitigate the change in estimated payments for IRFs.

The last one-year budget neutral blended transition policy we analyzed would allow all IRFs to transition from an MSA-based wage index to a CBSA-based wage index. This transition policy would be comprised of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006

CBSA-based wage index (both based on the FY 2001 hospital wage data) for all IRFs. As discussed in the FY 2006 IRF PPS proposed rule (70 FR 30188), the one-year blended wage index for all IRFs would result in a slight decrease of budget neutrality factor applied to the base rates from 0.9996 if there was no transition to 0.9995 under this transition policy. As a result, the budget neutrality factor applied to the unadjusted payment amount would reduce the unadjusted payment amount by approximately 1 dollar as compared to fully adopting the CBSA-based designations. This slight decrease to the unadjusted payment amount will lessen the overall payment reduction impact on all providers - regardless of urban or rural designations.

Although a blended wage index for all IRFs would also help IRFs that are adversely affected by the changes from MSAs to CBSAs, it would reduce the expected higher CBSA wage index values for IRFs that are positively affected by the changes (compared to fully adopting the CBSA-based wage index). To clarify, a blended wage index for IRFs that experience any increase due to the change from an MSA-based wage index to a CBSA-based wage index would be lessened. Thus, this would allow all IRFs one year to financially prepare for a change in wage index due to the change from FY 2005 MSA-based to FY 2006 CBSA-based designations - regardless of an increase or decrease in wage index.

In addition, although the blended wage index would limit the wage index increase for IRFs that experience an increase due to the change from an MSA-based wage index to a CBSA-based wage index during FY 2006, these IRFs will continue to see an increase in their wage index. However, the dampening effect of the blended wage index for IRFs that experience an increase in their wage index does not significantly impact these IRFs based solely on the wage index. The increase in the wage index these IRFs would experience would still take effect because the blended wage index would be an average of the MSA-based wage index and a CBSA-based wage index and the CBSA-based wage index would be greater than the MSA-based wage index. Therefore, IRFs in this scenario would not be significantly impacted by a blended wage index. In other words, IRFs that have higher CBSA wage index values and are subject to the blend will continue to have a benefit of having their payment derived, in part, from the higher CBSA wage index. We believe this option helps create an equitable situation for all IRFs.

Many commenters urged and supported a transition to adopting the CBSA-based designations. Thus, this blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index and both based on the FY 2001 hospital wage data) would provide IRFs a one-year transition from the MSA-based designations to the

CBSA-based designations. In addition, the one year transition of a blended wage for all IRFs would result in 93 percent of all IRFs experiencing a wage index change between a decrease by up to 2 percent or an increase by up to 2 percent. In any given year, even under the MSA-based wage index, many IRFs experience a 2 percent change in wage index and this 2 percent change would most likely be a wage index change that would not significantly impact IRF payments based solely on the wage index. Thus, from year to year, almost all IRFs are expected to experience a minimal change in wage index values. In comparison, if we fully adopted the CBSA-based wage index without a transition as proposed, 85 percent of the IRFs would experience a change between a decrease by up to 2 percent or an increase by up to 2 percent. By providing a one year transition for all IRFs to receive a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index and both based on the FY 2001 hospital wage data), a larger majority of IRFs will experience a minimal change in wage index from FY 2005 to FY 2006.

We decided not to provide for a longer transition, as recommended by a few commenters, because we have already, in effect, provided one year at a higher wage index level for all IRFs by retaining the previous labor market definitions for two years after the new labor market definitions became

available. For example, we did not implement the new labor market area definitions as quickly as was done for facilities paid under the IPPS. Furthermore, since most IRFs benefit from a one year blended wage index, there will be minimal affect on IRFs. Thus, a one year transition is sufficient to minimize the impact of adopting the CBSA-based designations because we believe that the transition period allows IRFs sufficient time to adjust their necessary business practices. In addition to the one year blended wage index, we are implementing a longer, 3-year hold harmless transition (as discussed in this section below of this final rule (section VI.B.2.e)) for a group of IRFs that during FY 2005 are as designated as rural, and for FY 2006 will be designated as urban under the new CBSA-based geographic designation method. We are implementing a longer hold harmless transition for these IRFs because, as a group they experience a reduction in payments due to the labor market revisions and the loss of the rural adjustment.

The statute confers broad authority to the Secretary under 1886(j)(6) of the Act to establish factor for area wage differences by a factor such that budget neutral wage index options may be considered. After consideration of the recommendations presented by the commenters and based on our further analysis, we will implement a budget neutral one-year transition policy such that a blended wage index (50

percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index that are both based on the FY 2001 hospital wage data) will apply to all IRFs. This transition policy will be effective for discharges occurring on or after October 1, 2005 and on or before September 30, 2006. This transition will mitigate the large negative impacts for IRFs that experience a decrease in the wage index and allow all IRFs to transition from the MSA-based wage index to the CBSA-based wage index for one-year. Therefore, for FY 2007 and subsequent years, we will adopt the full CBSA-based wage index for all IRFs.

Comment: Several commenters requested CMS to consider a multi-year hold harmless policy as was implemented by IPPS.

Response: As discussed in the August 11, 2004 IPPS final rule (69 FR at 49032), during FY 2005, a hold harmless policy was implemented to minimize the overall impact of hospitals that were in FY 2004 designated as urban under the MSA designations, but will become rural under the CBSA designations. In the same final rule, hospitals were afforded a three-year hold harmless policy because the IPPS determined that acute-care hospitals that changed designations from urban to rural will be substantially impacted by the significant change in wage index. Although we considered a hold harmless policy in our FY 2006 proposed

rule, we did not propose a hold harmless policy because we believed that rural IRFs (under the MSA-based designations) that change to an urban designation (based on the CBSA-based geographic classification) would experience a significant increase to the wage index under the CBSA-based designations that would mitigate a significant decrease in payments. However, many commenters urged CMS to reconsider a hold harmless policy because the commenters demonstrated that some rural facilities would experience undue hardship with the loss of the rural adjustment under §412.624(e) (3).

In our analysis (discussed in the FY 2006 IRF PPS proposed rule (70 FR 30188)), we found that 91 percent of rural facilities that would be designated as urban under the CBSA-based definitions will experience an increase in the wage index. A majority (74 percent) of rural facilities that become urban will experience at least a 5 percent to 10 percent or more increase in wage index. Although these rural IRFs experience wage index increases, several commenters emphasized that a majority of rural providers that change designations may experience a wage index increase of at least 5 percent or more, the loss of the rural adjustment would be such a large negative impact on the rural IRFs that it may potentially cause undue hardship for these rural facilities.

In response to the commenters concerns, we considered

different hold harmless policies such as a multi-year hold harmless policy as well as a phase-out of the rural adjustment for rural IRFs under the MSA-based designations that received a rural adjustment of 19.14 percent in FY 2005. A commenter recommended a phase-out of the FY 2005 rural adjustment of 19.14 percent because this option allows IRFs that change designations, from rural to urban, time to adjust to the loss of the 19.14 percent rural adjustment which would result in loss of payments. Other commenters concurred that the loss of the FY 2005 rural adjustment far exceeds the urban CBSA-based increase in wage index. Thus, commenters believed that this would have significant payment implications, particularly large negative impacts for rural IRFs that change designations because they will experience significant payment losses.

After further consideration of hold harmless policies as recommended by commenters, we have decided to implement a hold harmless policy to mitigate significant payment implications, particularly large negative impacts. We will implement a 3 year budget neutral hold harmless policy for those IRFs that meet the definition in §412.602 as rural in FY 2005 and will become urban under the FY 2006 CBSA-based designations. We will afford existing IRFs designated in FY 2005 as rural IRFs (pursuant to §412.602) and redesignated as an urban facility in FY 2006 (pursuant to §412.602) in FY

2006, whose payment is lower because of such redesignation, a 3 year time span to adjust to the loss of the FY 2005 rural adjustment of 19.14 percent because the loss of the 19.14 percent rural adjustment would result in a significant loss of payments. This adjustment will be in addition to the one-year blended wage index (comprised of FY 2006 MSA-based wage index and FY 2006 CBSA-based wage index both based on FY 2001 hospital data) for all IRFs.

Although our intent under our hold harmless policy is to mitigate the negative payment effect upon a rural facility that is redesignated as an urban facility (effective FY 2006), the hold harmless policy should not result in an IRF that comes under the hold harmless policy to realize greater payments than the IRF would have if instead the IRF would have been paid under its rural designation in FY 2006 including the FY 2005 rural adjustment of 19.14 percent. Therefore, we will make the appropriate payment modification to the additional adjustment made under our hold harmless policy so that an existing FY 2005 rural IRF that is redesignated from rural to urban in FY 2006 will in FY 2006 or FY 2007 not realize payments that are greater than what the payments would have been if the facility would have instead been paid under its rural designation designation in FY 2006 including the FY 2005 rural adjustment of 19.14 percent. In other words, if

an existing FY 2005 IRF is redesignated from rural to urban in FY 2006, and it will realize an increase in payments during the one year transition due to the hold harmless policy, it will not received the full two-thirds of the 19.14 percent rural adjustment. However, if this same IRF realizes a decrease in payment in FY 2007 solely because of such redesignation in FY 2006, it will receive one-third of the 19.14 percent rural adjustment in such case.

As stated above, the hold harmless policy is specifically for FY 2005 rural IRFs that become urban in FY 2006 and that experience a loss in payment because of this redesignation. Thus, we are not implementing a hold harmless policy for urban facilities (under the MSA-based designation) that become rural (under the CBSA-based designation) because these IRFs will receive the updated FY 2006 rural adjustment of 21.3 percent that they did not receive in FY 2005 as an urban facility. The gain of this payment adjustment should more than mitigate the loss of the wage index decreases associated with the rural designations. For FY 2005, rural facilities that remain rural under the FY 2006 CBSA-based designation, we are not extending the hold harmless policy for these IRFs because these rural IRFs will receive the updated FY 2006 rural adjustment of 21.3 percent, which is higher than the FY 2005 rural adjustment of 19.14 percent. We are also not extending the hold

harmless policy for facilities that remain in their urban geographic designations from the MSA-based designation to the CBSA-based designation because we have mitigated the impact of the change in wage index value by implementing a one year transition wage index (comprised of 50 percent FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index) for all IRFs as discussed in detail above. As was previously stated, the purpose of the hold harmless policy is to mitigate the significant payment implications for existing rural IRFs that may need time to adjust to the loss of their FY 2005 rural payment adjustment that experience a reduction in payments solely because of such redesignation. Our decision to implement the hold harmless policy only for existing FY 2005 rural IRFs that will be adversely impacted, is supported by comments received primarily requesting implementation of a method that mitigates the adverse payment impacts because of the loss of the rural adjustment.

Due to our review and analysis, we determined that a 3 year budget neutral hold harmless policy would best accomplish the goals of mitigating the loss of the rural adjustment for existing FY 2005 rural IRFs. The incremental steps needed to reduce the impact of the loss of the FY 2005 rural adjustment of 19.14 percent will be phase out for years FY 2006, FY 2007, and FY 2008.

Thus, the budget neutral 3 year hold harmless policy will apply to the existing FY 2005 rural IRFs (under the MSA-based designation) that will change designations and experience a reduction in payments due to the loss of the FY 2005 rural adjustment of 19.14 percent and meets the intent of this policy. The hold harmless policy will allow existing FY 2005 rural IRFs adversely affected by the change in designation to receive two-thirds of the FY 2005 rural adjustment of 19.14 percent (specifically 12.76 percent hold harmless adjustment) for FY 2006 as well as the blended wage index (comprised of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index both based on FY 2001 hospital data). For FY 2007, existing FY 2005 rural IRFs that are a part of the FY 2006 hold harmless policy will receive the full FY 2007 CBSA wage index and one-third of the FY 2005 rural adjustment of 19.14 percent (specifically, a 6.38 percent hold harmless adjustment). For FY 2008, existing FY 2005 rural IRFs that are a part of the FY 2006 hold harmless policy will receive the full FY 2008 CBSA-based wage index without a rural adjustment as long as the IRF is designated as urban under the FY 2008 CBSA-based designation (illustrated in Table 10 below).

Table 10: IRF 3-Year Hold Harmless Policy for IRFs designated as Rural under the MSA-based designation

	FY 2006	FY 2007	FY 2008
Wage Index	50% of MSA Wage Index and 50% of CBSA Wage Index	Full FY 2007 CBSA Wage Index	Full FY 2008 CBSA Wage Index
*Rural Adjustment (Phase out)	12.76%	6.38%	N/A

*Based on the FY 2005 Rural Adjustment of 19.14 percent.

As is shown by the table, making incremental reductions to the 19.14 percent rural adjustment that certain rural IRFs received during FY 2005 results in these IRFs still being paid a portion of that rural adjustment in FY 2006 and FY 2007.

We believe that an incremental reduction of the FY 2005 rural adjustment of 19.14 percent is appropriate because of our analysis to implement a one third compared to a two thirds hold harmless adjustment of the 19.14 percent rural adjustment in FY 2006. We analyzed the 34 IRFs (in our analysis file) that would be impacted by the hold harmless policy to determine the effect on their IRF PPS payments if we did not implement a hold harmless policy. We also reviewed the payment impacts on these IRFs if the hold harmless policy implemented one third of the FY 2005 rural adjustment of 19.14 percent versus two thirds of the FY 2005 rural adjustment of 19.14 percent in FY 2006 (as described in the section XII).

We found that if we did not adopt a hold harmless

policy, the 34 rural IRFs that change designations from a rural facility (under the MSA-based designations) to an urban facility (under the CBSA-based designations) would experience a significant reduction in per case payment. We also considered a one year hold harmless policy that would allow the 34 IRFs in our analysis to receive a blended wage index as well as only a one third of the FY 2005 rural adjustment of 19.14 percent. Based on our analysis, a one year hold harmless policy would slightly mitigate the payment reductions for rural IRFs in our analysis file.

Our analysis of whether a multi-year hold harmless policy would provide a sufficient buffer to the loss of payments, found that a 3 year hold harmless policy of two thirds of the 19.14 percent rural adjustment in the FY 2006 and one third in FY 2007 would be the most appropriate. Based on a 3 year hold harmless policy, we found these IRFs would be mitigated from significant payment reductions. We determined that a 3 year hold harmless policy that provides two thirds of the 19.14 percent adjustment in FY 2006 and one third in FY 2007 would appropriately mitigate the adverse payment impacts for existing FY 2005 rural IRFs that are designated as urban IRFs in FY 2006.

To determine whether an existing FY 2005 rural IRF would meet part of the criteria for the hold harmless policy, we have developed Table 2 in the addendum. Table 2 of this addendum is a crosswalk file of counties/areas in the United States and Puerto Rico that would change from a

rural MSA-based designation to an urban area under the CBSA-based designation. These areas are listed in Table 2 of the addendum to identify areas affected by the budget neutral 3 year hold harmless policy as described in this section.

Table 2 of the addendum provides the State and county code, State and county name, MSA number, MSA rural designations, FY 2006 MSA-based wage index, FY 2006 CBSA-based wage index, CBSA number, CBSA urban designations, and the applicable FY 2006 transition wage index as described in section VI.2.B.e. The FIs will also be instructed to use Table 2 of the addendum to identify IRFs in these areas that will be impacted by the budget neutral 3 year hold harmless policy (as discussed in detail in this section) based on the FI's existing data in the provider specific file.

As a conforming change to §412.624(e), we are finalizing the hold harmless policy by adding new paragraph (e) (7). Paragraph (e) (7) of §412.624(e) will read as follows: Adjustments for certain facilities geographically redesignated in FY 2006.

(i) General. For a facility defined as an urban facility under §412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under §412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY

2006 and it no longer qualified for the rural adjustment under §412.624(e) (3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) Exception. For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e) (7) (i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under §412.624(e) (3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e) (7) (i) (A) and (e) (7) (i) (B) of this section as determined by us.

In addition, we did not receive comments regarding section 505 of the MMA that established a new section 1886(d) (13) of the Act. As discussed in the FY 2006 IRF PPS proposed rule (70 FR 30188), the new section 1886(d) (13)

requires that the Secretary establish a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. We believe that this requirement for an "out-commuting" or "out-migration" adjustment applies specifically to the IPPS. Therefore, we are not implementing such an adjustment for the IRF PPS in this final rule.

Comment: A number of commenters advised us that Table 3 of the FY 2006 IRF PPS proposed rule contained a formatting problem that resulted in provider numbers, provider names, state and county location, MSA-based designation, and CBSA-based designations to be misaligned.

Response: Once this error was brought to our attention, we immediately published a public use file on our webpage to show the provider level table as developed in Microsoft Excel. The web address for the FY 2006 IRF PPS proposed rule's public use files may be found at

<http://www.cms.hhs.gov/providers/irfpps/fy06nprm.asp>.

Table 3, as published in the FY 2006 IRF PPS proposed rule (70 FR 30188), was produced for informational purposes only. Therefore, the information an IRF's FI has on file for each IRF will not be altered based on Table 3. We will not be reproducing a provider level table that crosswalks the MSA-based and CBSA-based designations for this final rule as it was only published in the proposed rule to help facilitate

the public's understanding of the proposed policy.

For the purposes of determining a wage index for FY 2006 IRF PPS rate year, we will publish a crosswalk table (Table 1 of this addendum) listing the State and county code, State and county name, the MSA-based designations, CBSA-based designations and the blended wage index (comprised of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-base wage index both based on the FY 2001 hospital wage data) for discharges occurring on or after October 1, 2005 and on or before September 30, 2006. In the FY 2006 IRF PPS proposed rule (70 FR 30188), we published a FY 2006 CBSA urban and rural wage index table to illustrate the proposed policy to fully adopt the FY 2006 CBSA wage index. Since we are no longer fully adopting the FY 2006 CBSA wage index, we will publish a table for FIs to determine an IRFs blended wage index values for FY 2006 (specifically a blend of 50 percent FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index). Thus, Table 1 of this addendum will be used by FIs to determine the FY 2006 one-year blended transitional wage index (comprised of FY 2006 MSA-based and FY 2006 CBSA-based wage index) as finalized in this rule.

Final Decision: In summary (as discussed in detail above in the comments and responses, and based on further analysis of various policy options to implement the CBSA-

based designations), we will implement a budget neutral one-year transition policy that blends the FY 2006 MSA-based wage index and FY 2006 CBSA-based wage index (both based on FY 2001 hospital wage data) for discharges occurring on or after October 1, 2005 and on or before September 30, 2006 for all IRFs. In addition to the blended wage index for FY 2006, we will implement a budget neutral 3 year hold harmless policy for existing FY 2005 rural IRFs that will lose the FY 2005 rural adjustment of 19.14 percent, experience a loss in payments due to the change from an MSA-based rural designation to a CBSA-based urban designation, and meets the intent of the hold harmless policy (as discussed in detail above).

f. Wage Index Data

In the August 7, 2001 final rule, we established an IRF wage index based on FY 1997 acute care hospital wage data to adjust the FY 2002 IRF payment rates. For the FY 2003 IRF PPS payment rates, we applied the same wage adjustment as used for FY 2002 IRF PPS rates because we determined that the application of the wage index and labor-related share used in FY 2002 provided an appropriate adjustment to account for geographic variation in wage levels that was consistent with the statute. For the FY 2004 IRF PPS payment rates, we used the hospital wage index based on FY 1999 acute care hospital wage data. For the FY 2005 IRF PPS

payment rates, we used the hospital wage index based on FY 2000 acute care hospital wage data. As was proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188) and for this final rule, we will use FY 2001 acute care hospital wage data for FY 2006 IRF PPS payment rates because it is the most recent final data available. As was proposed in the FY 2006 IRF PPS proposed rule (70 FR 30188), and for this final rule, we will adopt the methodology discussed in the proposed rule (70 FR at 30188, 30241) to calculate a wage index in the event that there is no hospital data for an area (urban or rural) under the CBSA-based designations (70 FR 30188, 30241).

A summary of public comments and our responses on the wage index data are discussed below:

Comment: Many commenters argue that a majority of IRFs are hospital units and should be treated the same as hospitals whereby IRFs should be allowed to be reclassified to the same geographic area as the hospital. One commenter urged CMS to develop instructions and begin collecting IRF-specific wage index data in order to allow IRFs to establish a geographic reclassification criteria for IRFs. Commenters also urged CMS to use FY 2002 hospital wage data for the FY 2006 IRF PPS rate year because it is more current than the finalized data available. One commenter request that CMS develop a "rural floor" like that of IPPS.

Response: In the August 1, 2001 final rule (66 FR at 41358) we established FY 2002 IRF PPS wage index values for the 2002 IRF PPS fiscal year calculated from the same data used to compute the FY 2001 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act and without applying the "rural floor" under section 4410 of Pub. L. 105-33 (BBA) (as discussed in section VI.B.2.a of this final rule). Acute care hospital inpatient wage index data is also used to establish the wage index adjustment used in other PPSs (for example, LTCH, IPF, HHA, and SNF). As we discussed in the August 7, 2001 final rule (66 FR at 41316, 41358), since hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of this IRF data it is not appropriate at this time to implement a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree, if any, to which the acute care hospital data fully represent IRF wages or if a geographic reclassification adjustment under the IRF PPS is appropriate.

Although commenters request CMS to develop a "rural floor" like the IPPS, we believe the "rural floor" is applicable only to the acute care hospital payment system. Furthermore, as stated in section VI.B.2, section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) applies specifically to acute care hospitals and not excluded hospitals and excluded units. Thus, we believe that the acute care hospital "pre-reclassification and pre-floor" wage data is the best proxy and most appropriate wage index.

In addition and as discussed above in section VI.B.2.e we will implement a blended wage index to mitigate the impacts an IRF may experience as a result of the change from MSA-based designations to CBSA-based designations. Furthermore, under the IRF PPS, IRFs are paid a rural adjustment under §412.624(e) (3) as discussed in detail in section VI.B.4 to account for higher costs among rural facilities versus urban facilities.

Although commenters request instructions to be developed in order to collect IRF specific wage data, we did not propose to develop instructions at this time. At this time, we are unable to develop a separate wage index for rehabilitation facilities. Further, in order to accumulate the data needed, we would need to make modifications to the cost report. In the future, we will continue to research wage data specific to IRF facilities. Because we do not

have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represents IRF wages. However, we continue to believe it is an appropriate proxy because the hospital wage data is currently the most appropriate data for adjusting payments made to IRFs.

Several comments request the ability to allow IRFs to reclassify like that of acute care hospitals. To emphasize and as discussed in section VI.B.2, we believe that actual location of an IRF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which a facility is located influences the cost of a case. As demonstrated by the update rural adjustment and research conducted by RAND. The research and findings that update the rural adjustment is discussed in detail in section VI.B.4. We continue to review the facility adjustment to account for higher costs in different types of IRFs by updating our facility adjustments.

Final Decision: We believe that a wage index based on acute care hospital wage data is the best proxy and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same

labor markets. Since acute care hospitals compete in the same labor market areas as IRFs, the wage data of acute care hospitals would accurately capture the relationship of wages and wage-related costs of IRF in an area as comparable to the national average.

Therefore, as we proposed in the FY 2006 proposed rule (70 FR 30188) and for this final rule, we continue to believe that a wage index based on acute care hospital data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets. Also, we will continue to use the same method for calculating wage indices as was indicated in the August 7, 2001 final rule (69 FR at 41357 through 41358). In addition, 1886(d)(8) and 1886(d)(10) of the Act which permits reclassification is applicable only to inpatient acute care hospitals at this time. The wage adjustment established under the IRF PPS is based on an IRF's actual location without regard to the urban or rural designation of any related or affiliated provider. Therefore, we continue to believe reclassification of IRFs is inappropriate at this time.

In adopting the CBSA-based designations, we recognize that there may be geographic areas where there are no hospitals, and thus no hospital wage data on which to base the calculation of the IRF PPS wage index. We found that

for FY 2006, this occurred in two States -- Massachusetts and Puerto Rico -- where, using the CBSA-based designations, there were no hospitals located in rural areas. If, rural IRFs open in Massachusetts or Puerto Rico, for FY 2006, we proposed and for this final rule, we are using the rural FY 2001 MSA-based hospital wage data for that Massachusetts and Puerto Rico to determine the wage index of such IRFs. In other words, we proposed and as finalized in this final rule, we will use the same wage data (the FY 2001 hospital wage data) used to calculate the FY 2006 IRF wage index. However, as we proposed in the FY 2006 proposed rule (70 FR 30188), for this final rule, rather than using CBSA-based designations, we will use MSA-based designations to determine the rural wage index of any States where there is no wage data available under the CBSA-based designations. By using such MSA-based designations there will be rural wage indices for both Massachusetts and Puerto Rico. We believe this is the most reasonable approach, as we are using the same hospital wage data used to calculate the CBSA-based wage indices.

In the event this occurs in urban areas where IRFs are located, as we proposed in the FY 2006 proposed rule (70 FR 30188), for this final rule, we will use the average of the urban hospital wage data throughout the State as a reasonable proxy for the urban areas without hospital wage

data. Therefore, urban IRFs located in geographic areas without any hospital wage data will receive a wage index based on the average wage index for all urban areas within the State. This does not presently affect any urban IRFs for FY 2006 because there are no IRFs located in urban areas without hospital wage data. However, the policy will apply to future years when there may be urban IRFs located in geographic areas with no corresponding hospital wage data.

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

In addition, we note that the Secretary has broad authority under 1886(j)(6) to update the wage index on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Therefore, for FY 2006, as we proposed in the FY 2006 proposed rule (70 FR 30188), for this final rule, we will use FY 2001 MSA-based

hospital wage data for rural Massachusetts and rural Puerto Rico in the event there are rural IRFs in such States. To clarify for rural areas without hospital wage data, we will use the most recent final years wage index available. In addition, for FY 2006 and thereafter, we are finalizing our proposed policy to calculate a statewide urban average in the event that there exist urban IRFs in geographic areas with no corresponding hospital wage data. Although we solicited comments on these approaches to calculate the wage index values for areas without hospital wage data for this and subsequent fiscal years, we did not receive any comments regarding our proposed methodology as discussed in our FY 2006 IRF PPS proposed rule. As a result, for any urban areas where there is no urban hospital wage data, we will calculate an average of the urban hospital wage data throughout the State as a reasonable proxy.

For the reasons discussed above, as we proposed in the FY 2006 proposed rule (70 FR 30188), for this final rule, we will continue the use of the acute care hospital inpatient wage index data generated from cost reporting periods beginning during FY 2001 without taking into account geographic reclassification as specified under sections 1886(d)(8) and (d)(10) of the Act and without applying the "rural floor" under section 4410 of Pub. L. 105-33 (BBA) (as discussed in section VI.B.2.a of this final rule). We

believe that data from FY 2001 cost reporting periods to determine the applicable wage index values under the IRF PPS in this final rule are appropriate because these are the most recent final available data. These data are the same FY 2001 acute care hospital inpatient wage data that were used to compute the IPPS FY 2005 wage indices. The final IRF wage indices are computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage - the result is a wage index for each urban and rural area.

The one-year blended wage index values that are applicable for IRF PPS discharges occurring on or after October 1, 2005 and on or before September 30, 2006 are shown in Table 1 of the addendum of this final rule.

In addition, for this final rule as we proposed in the FY 2006 proposed rule (70 FR 30188), any adjustment or update to the IRF wage index made as specified under section 1886(j)(6) of the Act will be made in a budget neutral manner that assures that the estimated aggregated payments under this subsection in the FY year are not greater or less

than those that will have been made in the year without such adjustment. Therefore, as we proposed in the FY 2006 proposed rule (70 FR 30188), for this final rule, we will calculate a budget-neutral wage adjustment factor as specified in §412.624(e)(1). We will continue to use the following steps to ensure that the FY 2006 IRF standard payment conversion factor reflects the one-year blended FY 2006 MSA and CBSA wage indices (both based on FY 2001 hospital wage data) and to the labor-related share in a budget neutral manner:

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

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

Step 3 Divide the amount calculated in step 1 by the amount calculated in step 2, which equals the FY 2006 budget-neutral wage adjustment factor of 0.9995 (as discussed in section VI.B.7 and VI.B.8).

Step 4 Apply the FY 2006 budget-neutral wage adjustment factor from step 3 to the FY 2005 IRF PPS standard payment

conversion factor after the application of the market basket update, described above, to determine the FY 2006 standard payment conversion factor.

3. Teaching Status Adjustment

In the FY 2006 proposed rule (70 FR 30188), we proposed to implement a teaching status adjustment for IRFs that are, or are part of, teaching institutions. Section 1886 (j) (3) (A) (v) of the Act requires the Secretary to adjust the prospective payment rates for the IRF PPS by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under this authority, in the August 7, 2001 final rule (66 FR 41316, 41359), we considered implementing an adjustment for IRFs that are, or are part of, teaching institutions. However, because the results of our regression analysis, using FY 1999 data, showed that the indirect teaching cost variable was not significant, we did not implement a payment adjustment for indirect teaching costs in that final rule. The regression analysis conducted by RAND for the FY 2006 proposed rule (70 FR 30188), using FY 2003 data, shows that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs. Therefore, we proposed to establish a facility level adjustment to the Federal per discharge base rate for IRFs

that are, or are part of, teaching institutions for the reasons discussed below (the "teaching status adjustment").

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

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

Medicare makes direct graduate medical education (GME)

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

When the IRF PPS was implemented, we did not adjust payments to IRFs for indirect medical education costs because we did not find that adjustments for such costs were supported by the regression analyses or by the impact analyses. As discussed in the August 7, 2001 final rule (69 FR 41316, 41359), the indirect teaching variable was not significant for either the fully specified regression or the payment regression in RAND's analysis. Furthermore, the

impacts among the various classes of facilities reflecting the fully phased-in IRF PPS illustrated that IRFs with the highest measure of indirect teaching would lose approximately 2 percent of estimated payments under the IRF PPS when compared with payments under TEFRA rate-of-increase limits. These impacts did not account for changes in behavior that facilities were likely to adopt in response to the inherent incentives of the IRF PPS, and we believed that IRFs could change their behavior to mitigate any potential reduction in payments.

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

In conducting the analysis on the FY 2003 data, RAND used the resident counts that were reported on the hospital cost reports (worksheet S-3, Part 1, line 25, column 9 for freestanding IRF hospitals and worksheet S-3, Part 1, line 14 (or line 14.01 for subprovider 2), column 9 for rehabilitation units of acute care hospitals). That is, for the freestanding rehabilitation hospitals, RAND used the

number of residents and interns reported for the entire hospital. For the rehabilitation units of acute care hospitals, RAND used the number of residents and interns reported for the rehabilitation unit (reported separately on the cost report from the number reported for the rest of the hospital). RAND did not distinguish between different types of resident specialties, nor did they distinguish among the different types of services residents provide, because this information is not reported on the cost reports.

RAND used regression analysis (with the logarithm of costs as the dependent variable) to re-examine the effect of IRFs' teaching status on the costs of care. With FY 2003 data that include all Medicare-covered IRF discharges, RAND found a statistically significant difference in costs between IRFs with teaching programs and those without teaching programs in the regression analysis. The different results obtained using the FY 2003 data (compared with the 1999 data) may be due to improvements in IRF coding after implementation of the IRF PPS. More accurately coded data may have allowed RAND to determine better the differences in case mix among hospitals with and without teaching programs, which would then have allowed the effect of whether or not an IRF has a teaching program to become significant in the regression analysis. There are two main reasons that indirect operating costs may be higher in teaching

hospitals: (1) because the teaching activities themselves result in inefficiencies that increase costs, and (2) because patients needing more costly services tend to be treated more often in teaching hospitals than in non-teaching hospitals, that is, the case mix that is drawn to teaching hospitals. Quantifying more precisely the amount of cost increase that is due to teaching hospitals' case mix allows RAND to more precisely quantify the amount of increase due to the inefficiencies associated with a teaching program.

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

As in the IPF PPS, we proposed to calculate a teaching adjustment based on the IRF's "teaching variable," which would be one plus the ratio of the number of FTE residents

training in the IRF (subject to limitations described further below) to the IRF's average daily census (ADC). In RAND's cost regressions for the FY 2006 proposed rule (70 FR 30188), using data from FY 2003, the logarithm of the teaching variable had a coefficient value of 1.083. We proposed to convert this cost effect to a teaching status payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value, then estimated at 1.083 (that is, the teaching status adjustment would be calculated by raising the teaching variable $(1 + \text{FTE residents}/\text{ADC})$ to the 1.083 power). For a facility with a teaching variable of 0.10, and using a coefficient based upon the coefficient value (1.083) from the FY 2003 data, this method would yield a 10.9 percent increase in the per discharge payment; for a facility with a teaching variable of 0.05, the payment would increase by 5.4 percent. We note that the coefficient value of 1.083 was based on regression analysis holding all other components of the payment system constant. In the FY 2006 proposed rule (70 FR 30188) we noted that, because we were proposing a number of other revisions to the payment system, the coefficient value was subject to change for the final rule depending on the other revisions included in the final rule. Moreover, we noted that we had concerns that IRFs' responses to other proposed changes described in the FY 2006

proposed rule (70 FR 30188) would influence the effects of a teaching variable on IRFs' costs.

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

The proposed FTE resident cap would be identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. Similar to the regulations for counting FTE residents under the IPPS as described in §412.105(f), we proposed to calculate a number of FTE residents that trained in the IRF

during a "base year" and use that FTE resident number as the cap. An IRF's FTE resident cap would ultimately be determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003. We also proposed that, similar to new IPPS teaching hospitals, IRFs that first begin training residents after November 15, 2003 would initially receive an FTE cap of "0". The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e) for IPPS hospitals. However, contrary to the policy for IME FTE resident caps under the IPPS, we would not allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. We proposed these policies because we believe it is important to limit the total pool of resident FTE cap positions within the IRF community and avoid incentives for IRFs to add FTE residents in order to increase their payments. In proposing not to allow affiliation agreements, we also wanted to avoid the possibility of hospitals transferring residents between IPPS and IRF training

settings in order to increase Medicare payments. We recognize that under the regulations applicable to the IPPS IME adjustment, a new teaching hospital that trains residents from an existing program (not a new program as defined in 42 CFR 413.79(1)) can receive an adjustment to its IME FTE cap by entering into a Medicare GME affiliation agreement (see §412.105(f)(1)(vi), §413.75(b), and §413.79(f)) with other hospitals. However, this option would not be available to new teaching IRFs because, as noted above, we proposed not to allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching adjustment through affiliation agreements.

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

We proposed that the denominator used to calculate the teaching status adjustment under the IRF PPS would be the IRF's average daily census (ADC) from the current cost

reporting period because it is closely related to the IRF's patient load, which determines the number of interns and residents the IRF can train. We also believe the ADC is a measure that can be defined precisely and is difficult to manipulate. Although the IPPS IME adjustment uses the hospital's number of beds as the denominator, the capital PPS (as specified at \$412.322) and the IPF PPS (as specified at \$412.424) both use the ADC as the denominator for the indirect graduate medical education adjustments.

If a rehabilitation hospital or unit has more FTE residents in a given year than in the base year (the base year being used to establish the cap), we would base payments in that year on the lower number (the cap amount).

This approach would be consistent with the IME adjustment under the IPPS and the IPF PPS. The IRF would be free to add FTE residents above the cap amount, but it would not be allowed to count the number of FTE residents above the cap for purposes of calculating the teaching adjustment. This means that the cap would be an upper limit on the number of FTE residents that may be counted for purposes of calculating the teaching status adjustment. IRFs could adjust their number of FTE residents counted for purposes of calculating the teaching adjustment as long as they remained under the cap.

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

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

An adjustment to payments based on an IRF's teaching status is consistent with section 1886 (j) (3) (A) (v) of the Act, which confers broad statutory authority upon the Secretary to adjust the per payment unit payment rate by such factors as the Secretary determines are necessary to

properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In the FY 2006 proposed rule, we discussed some concerns we had with implementing a teaching status adjustment at this time, including concerns about the volatility of the data, concerns about the effect that other proposed changes could have on the magnitude of the teaching status adjustment, and concerns about the best way to count residents who provide services to IRF patients. These concerns are described in more detail in the FY 2006 proposed rule (70 FR 30188). As a result of these concerns, we specifically solicited comments on our consideration of a teaching status adjustment.

Public comments and our responses on the proposed teaching status adjustment are summarized below.

Comment: Several commenters questioned CMS's rationale for not allowing affiliation agreements, if CMS is only concerned about not increasing the pool of residents in IRFs. One commenter suggested that allowing affiliation agreements among IRFs would not necessarily increase the total pool of residents in IRFs.

Response: In the FY 2006 proposed rule (70 FR 30188), we stated that we are not allowing IRFs to enter into affiliation agreements with IPPS hospitals for the purposes of aggregating the FTE resident caps because we want to

avoid the possibility that hospitals will transfer residents between IPPS and IRF training settings in order to increase Medicare payments. In deciding on our proposal not to allow affiliation agreements under the IRF PPS, we considered several factors. First, in general, we considered that IPPS hospitals provide training to residents in a wide range of specialties. Because of the wide variety of training provided, IPPS hospitals often need to send residents to train at other hospitals, since the case mix of one hospital might not be sufficiently broad to provide residents with an acceptable range of training opportunities in a particular specialty. The broad nature of the training offered at IPPS hospitals, and hence, the need to cross-train residents, is a primary reason for permitting IPPS hospitals under the Balanced Budget Act of 1997 to enter into GME affiliation agreements with other IPPS hospitals. However, because IRFs are a highly specialized type of provider, we do not believe that a significant amount of cross-training is required among IRFs. Although we imagine that there could be instances in which residents training in one IRF could receive a different type of training experience in another IRF, we believe these situations are likely to be limited and do not warrant having an affiliation agreement policy to allow IRFs to aggregate their FTE resident caps for the teaching status adjustment. Furthermore, we note that even

without a specific affiliations policy, IRFs are not precluded from cross-training residents amongst themselves or with IPPS hospitals. If cross-training is necessary, it can be done in such a way that the overall number of FTE residents training in each facility remains unchanged. Accordingly, we are finalizing our proposed policy to not create a specific GME affiliation provision for the IRF teaching status adjustment. In the future, if we find there is in fact a need to allow affiliation agreements among IRFs, we may consider revising this policy in a future rulemaking process.

Comment: Several commenters noted possible inaccuracies in the teaching status information for a few of the facilities in the rate setting file we posted on the CMS website in conjunction with the FY 2006 proposed rule (70 FR 30188).

Response: To clarify, the rate setting file posted on the CMS website will not be used to determine payments for providers. The fiscal intermediaries use their own data files to determine whether the IRFs under their responsibility qualify for teaching status adjustment payments and the amounts of any such payments. Therefore, if providers have concerns about their particular teaching status data, they should contact their fiscal intermediaries

to ensure that the fiscal intermediaries have the correct information.

With regard to the information in the rate setting file posted on the CMS website, this information was used to compute the value of the coefficient used as the exponent in the formula for the proposed teaching status adjustment. Consequently, we asked RAND to investigate the accuracy of the information. RAND has made the appropriate corrections to the information and, using the revised information, has recomputed the coefficient used as the exponent. Based on this and the incorporation of the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule), we have revised the exponent from 1.083, which is what we had proposed in the FY 2006 proposed rule (70 FR 30188), to 0.9012 for this final rule.

Comment: Several commenters objected to our proposal to implement the proposed teaching adjustment based on analysis of one year of data. However, several other commenters suggested that such concerns were unfounded and did not warrant overriding RAND's statistically valid findings.

Response: Since publication of the FY 2006 proposed rule (70 FR 30188), RAND has further analyzed FY 2002 and FY 2003 data, and has found that the teaching status variable is significantly related to costs in both sets of data.

Furthermore, we believe that IRFs with teaching programs may have been underrepresented in the 1998 and 1999 data used to construct the IRF PPS, and that this may have contributed to the lack of a statistically significant finding using the pre-PPS data. In addition, the statistically significant difference in costs between teaching and non-teaching facilities has been validated in other inpatient settings, including IPPS hospitals and IPFs. Therefore, we are reassured that this result does not represent an aberration based on only a single year's data, but instead represents a result of using more recent, more complete data. However, we will continue to evaluate the need for this adjustment in the future. If we later find that the other refinements described in this final rule constitute enough of an improvement to the system by more appropriately accounting for the variation in costs among different types of IRF patients that the teaching status adjustment becomes unnecessary, we will consider eliminating the adjustment in the future. However, we believe there is enough evidence at this time that IRFs with teaching programs have higher costs to implement the adjustment.

Comment: One commenter requested that CMS change the data that will be used to establish the FTE resident cap for IRFs from our proposal to use IRFs' most recent cost reporting periods ending on or before November 15, 2003, to

use IRFs' most recent cost reporting periods ending on or before November 15, 2004 to ensure that the FTE resident caps will be based on the most accurate historical resident count data possible.

Response: We agree with this commenter and are revising our methodology for setting the FTE resident cap accordingly. Since we published the FY 2006 proposed rule (70 FR 30188), the FTE resident cap used for the teaching status adjustment for IPFs has been set similarly based on cost reporting periods ending on or before November 15, 2004. We believe this change is appropriate and maintains consistency within the Medicare program.

Comment: One commenter requested that CMS have a process in place for re-examining the teaching status data, especially the data used to set the FTE resident cap, so that facilities would have the opportunity to rectify any problems with the data that might affect payments.

Response: We agree with this commenter. We recognize that there may be problems with some of the resident count data on the historical cost reports, since this data has not previously been used for payment adjustments in the IRF PPS.

For this reason, we proposed in the FY 2006 proposed rule (70 FR 30188) that an IRF's FTE resident cap would ultimately be determined based on the final settlement of the IRF's most recent cost reporting period ending on or

before November 15, 2003 and, based on this and the previous comment (refer to the response above), we are changing this to the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. We believe this will allow facilities the opportunity to ensure the accuracy of the FTE resident count data before the final settlement of the cost report data. In case this does not occur, we will authorize the fiscal intermediaries to resolve any disputes that may occur regarding the data used to set an IRF's FTE resident cap and correct any inaccuracies.

With regard to the FTE resident count data or the average daily census data used to compute an IRF's teaching status adjustment, we specifically note in this final rule that any teaching status adjustments for the IRF PPS facilities will be made on a claim basis as interim payments, but the final payments in full for the cost reporting periods will be made through the final settlement of the cost report. The difference between the interim payments and the actual teaching status adjustment amounts computed in the cost reports will be adjusted through lump sum payments/recoupments when the cost report is filed and later settled. We believe this process gives providers and fiscal intermediaries ample opportunity to ensure that the data used to compute the teaching status adjustment payments

is as complete and accurate as possible. As the proposed teaching status adjustment is implemented, we will monitor the situation and issue further guidance to the fiscal intermediaries as necessary to ensure fair and accurate payments for this adjustment.

Comment: The majority of commenters expressed support for CMS eventually implementing an IRF teaching status adjustment, especially since teaching IRFs were likely underrepresented in the 1998 and 1999 data used in the August 7, 2001 final rule to design the IRF PPS. However, while supporting the adjustment, several commenters suggested that CMS wait to implement a teaching status adjustment for at least a year, until data from FY 2004 (or later) can be analyzed.

Response: CMS considered carefully the suggestion to wait an additional year or more before implementing the proposed teaching status adjustment. However, RAND's regression analyses of calendar year 2002 and FY 2003 data both support the need for a teaching status adjustment for IRFs because they both indicate that IRFs with teaching programs have significantly higher costs than IRFs without teaching programs. Given RAND's findings, we believe it is important to adjust IRF payments accordingly in order to better align IRF payments with the costs of care. In addition, we believe it is important to maintain consistency

with other parts of the Medicare program, such as the IPF PPS that recently instituted a teaching status adjustment for IPFs based on regression analysis that shows that IPFs with teaching programs have significantly higher costs than IPFs without teaching programs.

Comment: Several commenters strongly disagreed with the proposed implementation of a teaching status adjustment for IRFs. Among the reasons cited were that it was based on analysis of a single year of data, that it would support inefficiencies in teaching hospitals (when the purpose of a PPS is to encourage providers to operate efficiently), that the data do not adequately support the need for a teaching status adjustment, that it would reduce payments to non-teaching hospitals, and that teaching hospitals would likely continue to operate even if they do not receive the adjustment.

Response: We carefully considered these comments. However, we continue to believe that an IRF teaching status adjustment is warranted at this time because RAND's regression analysis, based on calendar year 2002 and FY 2003 data shows that IRFs with teaching programs have significantly higher costs than non-teaching IRFs. Although we do not believe it is appropriate to encourage or perpetuate inefficiencies, we believe that IRFs with teaching programs provide a valuable service to

beneficiaries and to the Medicare program. To the extent that the residency training services, therefore, lead to higher indirect costs of providing care, we believe it is important to recognize these differences and encourage access to care in these facilities. While, as one commenter notes, teaching IRFs more than likely would continue to operate even without the IRF teaching status adjustment, the intent of the adjustment is to better align payments in these facilities with the costs of care.

Furthermore, we believe that IRFs with teaching programs may have been underrepresented in the 1998 and 1999 data used to construct the IRF PPS, and that this may have contributed to the lack of a statistically significant finding using the pre-PPS data. In addition, the statistically significant difference in costs between teaching and non-teaching facilities has been validated in other inpatient settings, including IPPS hospitals and IPFs.

We proposed, and are finalizing in this final rule, to implement the IRF teaching status adjustment in a budget neutral manner in order to ensure that estimated aggregate payments to IRFs for FY 2006 will be the same with or without the teaching status adjustment. Given that the impact on IRFs without teaching programs of this provision is not large (see Table 13 of this final rule), we do not believe that implementing the teaching status adjustment in

a budget neutral manner will unduly affect non-teaching IRFs. However, the teaching status adjustment will help to better align payments with the costs of care in teaching IRFs.

Furthermore, we believe that a teaching status adjustment for IRFs is consistent with the teaching status adjustment recently implemented in the IPF PPS.

Comment: One commenter suggested that CMS track the percentage of time residents spend in the rehabilitation unit of the hospital to compute the teaching adjustment, instead of using the resident and intern to ADC ratio we proposed in the proposed rule.

Response: This information is not currently captured in the cost report data, which would make this suggestion substantially more difficult to implement than the teaching status variable we proposed in the FY 2006 proposed rule (70 FR 30188). We also believe that collecting this type of information would impose additional costs on acute care hospitals that have IRF units, because they would be required to record the amount of time residents spend on rehabilitation units. We also believe that it would be difficult if not impossible to audit this type of information.

Comment: One commenter suggested that CMS focus the teaching adjustment on rehabilitation education programs, to the exclusion of other resident training programs.

Response: Information on resident specialties is not currently reported in the cost report data. We believe that collecting and reporting this new type of data would impose undue additional costs on IRFs and on hospitals that have IRF units. Furthermore, we believe that this policy would contradict the way that residency programs traditionally operate because they require residents from different specialties to rotate in different areas of the hospital to gain experience in various areas of medicine.

Comment: One commenter recommended that an exception process be allowed to enable IRF teaching programs to apply for an increase in their cap should a compelling reason arise, such as an expansion of the teaching hospital or unit or the addition of a new program.

Response: Similar to the GME resident cap policy for IPPS hospitals, we will not allow exceptions to the FTE resident caps for IRFs due to expansions of existing facilities or additions of new teaching programs. As we indicated previously, we believe it is important to limit the total pool of FTE resident cap positions within the IRF community.

Final Decision: After carefully considering all of the comments we received on the proposed IRF teaching status adjustment, we are finalizing our decision to adopt the proposed policy in this final rule, with the following revisions.

In RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule), the logarithm of the teaching variable has a coefficient value of 0.9012 (as opposed to the coefficient value of 1.083 we proposed in the FY 2006 proposed rule (70 FR 30188)). In the final policy, we are converting this cost effect to a teaching status payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value of 0.9012 (that is, the teaching status adjustment would be calculated by raising the teaching variable $(1 + \text{FTE residents}/\text{ADC})$ to the 0.9012 power).

Secondly, based on a commenter's suggestion, we are changing the base period for determining an IRF's FTE resident cap from the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003, which was what we had proposed in the FY 2006 proposed rule (70 FR 30188), to the final settlement of the IRF's most recent cost reporting period ending on or before

November 15, 2004. Thus, the policy in the IRF PPS would be consistent with the FTE resident cap policy in the IPF PPS.

4. Adjustment for Rural Location

In the FY 2006 proposed rule (70 FR 30188), we proposed to update the adjustment to the Federal prospective payment amount for IRFs located in rural areas from 19.14 percent to 24.1 percent, based on analysis of FY 2003 data. Consistent with the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we adjust the Federal prospective payment amount associated with a CMG to account for an IRF's geographic wage variation, low-income patients and, if applicable, teaching status and location in a rural area, as described in §412.624(e).

Under the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we proposed to increase the adjustment to the Federal prospective payment amount for IRFs located in rural areas from 19.14 percent to 24.1 percent. We proposed this change because RAND's regression analysis, using the best available data we had (FY 2003), indicated that rural facilities had 24.1 percent higher costs of caring for Medicare patients than urban facilities. We noted that we proposed to use the same statistical approach, as described in the November 3, 2000 proposed rule (65 FR 66304, 66356 through 66357) and adopted in the August 7, 2001 final rule (66 FR at 41359) to

estimate the proposed update to the rural adjustment. The statistical approach RAND used when the PPS was first implemented, for the FY 2006 proposed rule (70 FR 30188), and for this final rule relies on the coefficient determined from the regression analysis. The 19.14 percent rural adjustment has been applied to payments for IRFs located in rural areas since the implementation of the IRF PPS. We noted that the FY 2003 data are the best available data we have, just as the 1998 and 1999 data used in the initial development of the IRF PPS were the best available data at that time.

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

during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs.

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

Public comments and our responses on the proposed update to the rural adjustment are summarized below.

Comment: Overall, commenters generally supported this proposal. Some said that CMS should delay implementing the proposal until the full effects of the 75 percent rule can be analyzed.

Response: For the reasons discussed in section IV of this final rule, we do not believe we should wait until the full effects of the 75 percent rule can be analyzed before

implementing any of the proposed changes in this final rule.

Making the changes now does not preclude us from making additional revisions in the future if we find any potential effects of the 75 percent rule on IRFs' case mix or cost structures that would warrant such refinements.

Comment: One commenter expressed concerns that the proposed increases to the facility-level adjustments would encourage inefficiencies in the provision of care.

Response: While we agree with the commenter that one of the purposes of a PPS is to encourage the efficient provision of services, we also believe it is important to recognize that certain providers, such as those operating in rural areas, may incur higher costs than other providers, for reasons largely beyond their control. To encourage the efficient provision of care in rural areas, so that Medicare beneficiaries have adequate access to IRF services in these areas, we believe it is important to recognize the differential in costs between urban and rural providers.

Final Decision: After carefully considering all of the comments we received on this proposed change to the rural adjustment, we are finalizing our decision to adopt the update to the rural adjustment in this final rule, with the following change.

In RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data

from FY 2004 (as described in detail in section IV of this final rule), rural facilities were found to have 21.3 percent higher costs of caring for Medicare patients than urban facilities (rather than the 24.1 percent we proposed in the FY 2006 proposed rule (70 FR 30188)). Thus, we are implementing a rural adjustment of 21.3 percent.

5. Adjustment for Disproportionate Share of Low-Income Patients

In the FY 2006 proposed rule (70 FR 30188), we proposed to update the low-income patient (LIP) adjustment to the Federal prospective payment rate, based on analysis of FY 2003 data. Consistent with the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we adjust the Federal prospective payment amount associated with a CMG to account for an IRF's geographic wage variation, low-income patients and, if applicable, teaching status and location in a rural area, as described in §412.624(e).

Under the broad statutory authority conferred upon the Secretary in section 1886(j)(3)(A)(v) of the Act, we proposed to update the low-income patient (LIP) adjustment to the Federal prospective payment rate to account for differences in costs among IRFs associated with differences in the proportion of low-income patients they treat. RAND's regression analysis of 2003 data indicates that the LIP

formula could be updated to better distribute current payments among facilities according to the proportion of low-income patients they treat. Although the formula used prior to October 1, 2005 appropriately distributed LIP-adjusted payments among facilities when the IRF PPS was first implemented, we believe the formula should be updated from time to time to reflect changes in the costs of caring for low-income patients.

The proposed LIP adjustment is based on the formula used to account for the costs of furnishing care to low-income patients as discussed in the August 7, 2001 final rule (67 FR at 41360). We proposed to update the LIP adjustment from the power of 0.4838 to the power of 0.636. Therefore, the formula we proposed to use to calculate the LIP adjustment was as follows:

$$(1 + \text{DSH patient percentage})^{\text{raised to the power of } (0.636)}$$

Where the DSH patient percentage =

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

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

initial development of the IRF PPS were the best available data at that time.

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

This is consistent with section 1886 (j) (3) (A) (v) of the Act which confers broad statutory authority upon the Secretary to adjust the per payment unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. To ensure that total estimated aggregate payments to IRFs do not change, we

proposed to apply a factor to the standard payment amount to ensure that the estimated aggregate payments under this subsection in the FY are not greater or less than those that would have been made in the year without the proposed update to the adjustment. In sections VI.B.7 and VI.B.8 of this final rule, we discuss the methodology and factor we proposed to apply to the standard payment amount.

Public comments and our responses on the proposed update to the LIP adjustment are summarized below.

Comment: Overall, commenters generally supported this proposal. Some said that CMS should delay implementing the proposal until the full effects of the 75 percent rule can be analyzed.

Response: For the reasons discussed in section IV of this final rule, we do not believe we should wait until the full effects of the 75 percent rule can be analyzed before implementing any of the proposed changes in this final rule.

Making the changes now does not preclude us from making additional revisions in the future if we find any potential effects of the 75 percent rule on IRFs' case mix or cost structures that would warrant such refinements.

Comment: One commenter expressed concerns that the proposed increases to the facility-level adjustments would encourage inefficiencies in the provision of care.

Response: While we agree with the commenter that one of

the purposes of a PPS is to encourage the efficient provision of services, we also believe it is important to recognize that certain providers, such as those providers that treat a higher proportion of low-income patients, may incur higher costs than other providers, for reasons largely beyond their control. To encourage the efficient provision of care among providers that treat a large number of low-income patients, so that low-income Medicare beneficiaries have adequate access to IRF services, we believe it is important to recognize the higher costs these providers incur.

Final Decision: After carefully considering all of the comments we received on this proposed change to the LIP adjustment, we are finalizing our decision to adopt the proposed policy in this final rule, with the following change.

Based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule), we are updating the LIP adjustment to the power of 0.6229 (rather than the value of 0.636 we proposed in the FY 2006 proposed rule (70 FR 30188)). Therefore, the formula for calculating the LIP adjustment will be as follows: $(1 + \text{DSH patient percentage})$ raised to the power of (0.6229) where the DSH patient percentage =

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

6. Update to the Outlier Threshold Amount

In the FY 2006 proposed rule (70 FR 30188), we proposed to update the outlier threshold amount, based on analysis of FY 2003 data. Consistent with the broad statutory authority conferred upon the Secretary in sections 1886(j)(4)(A)(i) and 1886(j)(4)(A)(ii) of the Act, we proposed to update the outlier threshold amount from the \$11,211 threshold amount for FY 2005 to \$4,911 in FY 2006 to maintain total estimated outlier payments at 3 percent of total estimated payments. In the August 7, 2001 final rule, we discussed our rationale for setting estimated outlier payments at 3 percent of total estimated payments (66 FR at 41362). In the FY 2006 proposed rule (70 FR 30188), we proposed to continue using 3 percent for the same reasons outlined in the August 7, 2001 final rule. We believed and continue to believe that it is necessary to update the outlier threshold amount because RAND's analysis of the calendar year 2002 and FY 2003 data indicates that total estimated outlier payments will not equal 3 percent of total estimated payments in FY 2006 unless we update the outlier loss threshold. We will continue to analyze the estimated outlier payments for subsequent years and adjust as appropriate in order to maintain estimated outlier payments at 3 percent of total

estimated payments. The reasons for estimated outlier payments not equaling 3 percent of total estimated payments are discussed in more detail below.

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 final rule, we codified at §412.624(e)(4) of the regulations (which we proposed to redesignate as §412.624(e)(5) in the FY 2006 proposed rule (70 FR 30188)) the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in determining resource costs at the patient and facility level because facilities receive additional compensation over and above the adjusted Federal prospective payment amount for uniquely high-cost cases. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under §412.624(e)(4) (which we proposed to redesignate as §412.624(e)(5) in the FY 2006 proposed rule (70 FR 30188)), we would make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS

payment for the CMG plus the adjusted threshold amount. In the FY 2006 proposed rule (70 FR 30188), we proposed to make this \$4,911, which would then be adjusted for each IRF by the facility's wage adjustment, its LIP adjustment, its rural adjustment, and its teaching status adjustment, if applicable. In the FY 2006 proposed rule (70 FR 30188), we stated that we would calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with §412.624(e)(4) (which we proposed in the FY 2006 proposed rule (70 FR 30188) to redesignate as §412.624(e)(5)), we also stated that we would pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted fixed threshold dollar amount).

Consistent with the broad statutory authority conferred upon the Secretary in sections 1886(j)(4)(A)(i) and 1886(j)(4)(A)(ii) of the Act, and in accordance with the methodology stated in the August 1, 2003 final rule (68 FR at 45692 through 45693), we proposed in the FY 2006 proposed rule (70 FR 30188) to continue to apply a ceiling to an IRF's cost-to-charge ratios (CCR). Also, in the August 1, 2003 final rule (68 FR at 45693 through 45694), we stated the methodology we use to adjust IRF outlier payments

and the methodology we use to make these adjustments. We indicated that the methodology is codified in §412.624(e)(4) (which we proposed in the FY 2006 proposed rule (70 FR 30188) to redesignate as §412.624(e)(5)) and §412.84(i)(3).

On February 6, 2004, we issued manual instructions in Change Request 2998 stating that we would set forth the upper threshold (ceiling) and the national CCRs applicable to IRFs in each year's annual notice of prospective payment rates published in the **Federal Register**. The upper threshold CCR for IRFs that we proposed in the FY 2006 proposed rule (70 FR 30188) for FY 2006 would be 1.52 based on CBSA-based geographic designations. We proposed to base this upper threshold CCR on the CBSA-based geographic designations because the CBSAs are the geographic designations we proposed in the FY 2006 proposed rule (70 FR 30188) to adopt for purposes of computing the proposed wage index adjustment to IRF payments for FY 2006.

In addition, in the FY 2006 proposed rule (70 FR 30188), we proposed to update the national urban and rural CCRs for IRFs. Under §412.624(e)(4) (which we proposed in the FY 2006 proposed rule (70 FR 30188) to redesignate as §412.624(e)(5)) and §412.84(i)(3), we proposed to apply the national CCRs to the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.

- IRFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean.

- Other IRFs for whom accurate data with which to calculate either an operating or capital CCR (or both) are not available.

In the FY 2006 proposed rule (70 FR 30188), we proposed to use the national CCR based on the facility location of either urban or rural in each of the three situations cited above. Specifically, for FY 2006, we estimated a proposed national CCR of 0.631 for rural IRFs and 0.518 for urban IRFs. For new facilities, we proposed to use these national ratios until the facility's actual CCR could be computed using the first tentative settled or final settled cost report data, which would then be used for the subsequent cost report period.

In the August 7, 2001 final rule (66 FR at 41362 through 41363), we describe the process by which we calculate the outlier threshold. In the FY 2006 proposed rule (70 FR 30188), we proposed to use this same process for the FY 2006 IRF PPS. We proposed to simulate aggregate payments with and without an outlier policy, and then apply an iterative process to determine a threshold that would result in the simulated outlier payments being equal to 3 percent of total simulated payments under the simulation.

In the FY 2006 proposed rule (70 FR 30188), we noted that the simulation analysis used to calculate the proposed outlier threshold amount included all of the other proposed changes to the PPS discussed in the FY 2006 proposed rule (70 FR 30188). As stated in the FY 2006 proposed rule (70 FR 30188), we proposed to continue to analyze the estimated outlier payments for subsequent years and adjust as appropriate in order to maintain estimated outlier payments at 3 percent of total estimated payments.

In the FY 2006 proposed rule (70 FR 30188), we proposed to update the threshold amount so that estimated outlier payments would continue to equal 3 percent of total estimated payments under the IRF PPS. RAND found that 2002 outlier payments were equal to 3.1 percent of total payments in 2002. Nevertheless, the outlier loss threshold is affected by cost-to-charge ratios because the cost-to-charge ratios are used to compute the estimated cost of a case, which in turn is used to determine if a particular case qualifies for an outlier payment or not. For example, if the cost-to-charge ratio decreases, then the estimated costs of a case with the same reported charges would decrease. Thus, the chances that the case would exceed the outlier loss threshold and qualify for an outlier payment would decrease, decreasing the likelihood that the case would qualify for an outlier payment. If fewer cases were to

qualify for outlier payments, then total estimated outlier payments could fall below 3 percent of total estimated payments.

As we discussed in the FY 2006 proposed rule (70 FR 30188), our analyses of cost report data from FY 1999 through FY 2002 (and projections for FY 2004 through FY 2006) indicate that the overall cost-to-charge ratios in IRFs have been falling since the IRF PPS was implemented. We are still analyzing possible reasons for this finding. However, because cost-to-charge ratios are used to determine whether a particular case qualifies for an outlier payment, this drop in the cost-to-charge ratios is likely responsible for much of the drop in total estimated outlier payments below 3 percent of total estimated payments. Thus, as we discussed in the FY 2006 proposed rule (70 FR 30188), the outlier threshold would need to be lowered for FY 2006 in order that total estimated outlier payments would equal 3 percent of total estimated payments.

In addition, we proposed in the FY 2006 proposed rule (70 FR 30188) to adjust the outlier threshold for FY 2006 because RAND's analysis of calendar year 2002 and FY 2003 data indicates that many of the other proposed changes discussed in the FY 2006 proposed rule (70 FR 30188) would affect what the outlier threshold would need to be in order for total estimated outlier payments to equal 3 percent of

total estimated payments. The outlier loss threshold is affected by the definitions of all other elements of the IRF PPS, including the structure of the CMGs and the tiers, the relative weights, the policies for very short-stay cases and for cases in which the patient expires in the facility (that is, cases that qualify for the special CMG assignments), and the facility-level adjustments (such as the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment). In the FY 2006 proposed rule (70 FR 30188), we proposed to change many of these components of the IRF PPS. For the reasons discussed above and in the FY 2006 proposed rule (70 FR 30188), then, we believed and continue to believe that it is appropriate to update the outlier loss threshold for FY 2006. We also stated in the FY 2006 proposed rule (70 FR 30188) that we expect to continue to adjust the outlier threshold in the future when the data indicate that total estimated outlier payments would deviate from equaling 3 percent of total estimated payments.

Public comments and our responses on the proposed update to the outlier threshold amount are summarized below.

Comment: One commenter suggested that CMS notify fiscal intermediaries that, as a result of the lowering of the outlier threshold amount, more cases would likely qualify

for outlier payments. Such notification would enable the fiscal intermediaries to adjust their systems accordingly.

Response: We agree with the commenter's suggestion and will notify the fiscal intermediaries about the change to the outlier threshold amount and the implications of this for the number of cases that qualify for outlier payments.

Comment: Several commenters requested that CMS incorporate any unused outlier payments from years in which aggregate outlier payments are below the 3 percent target back into the base payments.

Response: We have responded to similar comments a number of times in the context of other prospective payment systems, including in rules at 70 FR 24168, 24196-24197, 57 FR 39784, 58 FR 46347, 59 FR 45408, 60 FR 45856, 61 FR 27496, and 56 FR 43227, 61 FR 46229-46230. As we have explained before and as explained below, we do not make adjustments to PPS payment rates to account for differences between projected and actual outlier payments in a previous year. We believe our outlier policies are consistent with the statute and the goals of the prospective payment system and are equitable.

In accordance with section 1886(j)(4) of the Act, we implemented the IRF PPS outlier policy at 42 C.F.R. section 412.624(d)(1). These regulations provide that CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section (which is redesignated as

(e) (5) in this final rule). We set outlier criteria before the beginning of each fiscal year so that outlier payments are projected to equal 3 percent of estimated total IRF PPS payments. In doing so, we use the best available data at the time to make our estimates. We do not believe that Congress intended that the standardized amounts for a given fiscal year should be adjusted (upward or downward) to reflect any difference between projected and actual outlier payments for a past year. Payments for a given discharge in a given fiscal year are generally intended to reflect or address the average costs of that discharge in that year; that goal would be undermined if we adjusted PPS payments to account for "underpayments" or "overpayments" in other years.

Outlier payments are "funded" through a prospective adjustment to the base rates. We do not set money aside into a discrete "pool" dedicated solely for outlier payments. Outlier payments are based on estimates. If outlier payments for a given year turn out to be greater than projected, we do not recoup money from hospitals; if outlier payments for a given year are lower than projected, we do not make an adjustment to account for the difference.

If estimates turn out to be inaccurate, we believe the more appropriate action is to continue to examine the outlier policy and to try to refine the methodology for setting outlier thresholds. Thus, consistent with this approach, for this final rule we are finalizing our decision to update

the outlier threshold amount to \$5,132 for FY 2006 to make estimated outlier payments equal to 3 percent of total estimated IRF PPS payments in FY 2006.

Comment: One commenter indicated a concern about the methodology used by CMS to estimate cost and charge growth for the purposes of calculating the outlier threshold amount. This commenter recommended an alternative methodology for the IPPS and encouraged CMS to apply that same methodology to the IRF PPS to ensure that the full 3 percent of outlier funds is used.

Response: We have reviewed the comments submitted for consideration in the IPPS, and we appreciate the alternative methodologies suggested by the commenters and have considered them carefully. The cost-to-charge ratio applied to charges provides Medicare the most accurate measure of a provider's per-case cost for the purpose of paying for high-cost outlier cases at the point that we process the initial claim. The cost-to-charge ratio is based on the providers' own cost and charge information as reported by the providers. For the purposes of this final rule, we have used the same methodology for projecting cost and charge growth that is used in the IPPS and in other Medicare payment systems, and we believe this methodology is appropriate for IRFs for the same reasons it is appropriate for IPPS hospitals. This methodology ensures that we pay

the appropriate amounts over and above the standard PPS payment amount for unusually high-cost cases.

Comment: Overall, commenters generally supported the proposal to decrease the outlier threshold. Some said that CMS should delay implementing the proposal until the full effects of the 75 percent rule can be analyzed.

Response: For the reasons discussed in section IV of this final rule, we do not believe we should wait until the full effects of the 75 percent rule can be analyzed before implementing any of the proposed changes in this final rule.

Making the changes now does not preclude us from making additional revisions in the future if we find any potential effects of the 75 percent rule on IRFs' case mix or cost structures that would warrant such refinements.

Final Decision: After carefully considering all of the comments we received on this proposed change to the outlier threshold amount, we are finalizing our decision to adopt the proposed policy in this final rule (including the redesignation of §412.624(e)(4) as §412.624(e)(5)), with the following change.

Using data from FY 2003, and including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule), RAND has calculated the outlier threshold amount of \$5,132 (instead of the \$4,911 outlier threshold amount we proposed in the FY 2006 proposed

rule (70 FR 30188)) that would maintain estimated outlier payments at 3 percent of total estimated IRF payments for FY 2006. Therefore, we are finalizing our decision to set the FY 2006 outlier loss threshold at \$5,132.

In addition, we are finalizing our decision to adopt the proposed upper threshold CCR for IRFs for FY 2006 of 1.52 based on CBSA-based geographic designations. We are basing this upper threshold CCR on the CBSA-based geographic designations because the CBSAs are the geographic designations we are adopting (with a one-year transition policy as described in section VI.B.2.e of this final rule) for the purposes of computing the wage index adjustment to IRF payments for FY 2006.

We are also finalizing our decision to update the national urban and rural CCRs for IRFs. Under §412.624(e)(4) (which we are redesignating as §412.624(e)(5) in this final rule), we will apply the national CCRs to the following situations:

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

an operating or capital CCR (or both) are not available.

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

7. Budget Neutrality Factor Methodology for Fiscal Year 2006

In the FY 2006 proposed rule (70 FR 30188), we proposed to make a revision (for FY 2006) to the methodology found in §412.624(d) in order to make the proposed changes to the tiers and CMGs, the rural adjustment, the LIP adjustment, and the proposed teaching status adjustment in a budget neutral manner. Accordingly, we proposed to revise §412.624(d) by adding a section §412.624(d)(4) for fiscal year 2006 and, as applicable, for fiscal years thereafter to the extent the adjustments are updated in the future. Specifically, we proposed to revise the methodology found in §412.624(d) by adding a new paragraph (d)(4). The addition of this paragraph would provide for the application of a

factor, as specified by the Secretary, which would be applied to the standard payment amount in order to make the proposed changes described in the preamble of the FY 2006 proposed rule (70 FR 30188) in a budget neutral manner for FY 2006. In addition, this paragraph would be used in future years if we propose refinements to the above-cited adjustments.

Final Decision: We did not specifically receive any comments on the proposed budget neutrality factor methodology for FY 2006. Therefore, we are finalizing our decision to adopt this budget neutrality factor methodology for FY 2006, with the change that we are incorporating HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) into the data we used previously to compute the budget neutrality factors. Based on RAND's analysis of FY 2003 data, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) and using the methodology described in section VI.B.8 of this final rule, we will apply the market basket increase factor (estimated for this final rule to be 3.6 percent) to the standard payment conversion factor for FY 2005 (\$12,958), which equals \$13,425. Then, we will apply a one-time reduction to the standard payment amount of 1.9 percent to adjust for coding changes that increased payment to IRFs (as discussed in section VI.A of this final rule), which equals \$13,169.

We will then apply the budget neutral wage adjustment (as discussed in section VI.B.2.f of this final rule) of 0.9995 to \$13,169, which will result in a standard payment amount of \$13,163. For FY 2006 and any applicable FYs thereafter, to the extent any of the adjustments are updated, we will apply budget neutrality factors to the standard payment amount using §412.624(c)(3)(ii), which incorporates by reference §412.624(d)(4), for the applicable changes to the tiers and CMGs, the rural adjustment, the LIP adjustment, and the teaching status adjustment we are finalizing in this final rule. We note that even if we do not update any of the adjustments (and therefore utilize §412.624(d)(4)), we will use §412.624(c)(3) to update the payment rates for FY 2006 and thereafter. The next section contains a detailed explanation of these budget neutrality factors we are finalizing in this final rule, including the steps for computing these factors and how they will affect total estimated aggregate payments and estimated payments to individual IRF providers. The factors we will apply (as discussed in the next section) are 0.9995 for the tier and CMG changes, 0.9889 for the teaching status adjustment, 0.9961 for the change to the rural adjustment, and 0.9851 for the change to the LIP adjustment. We have combined these factors, by multiplying the four factors together, into one budget neutrality factor for all four of these changes ($0.9995 * 0.9889 * 0.9961 * 0.9851 = 0.9699$). We will apply this overall budget neutrality factor to \$13,163,

resulting in a standard payment conversion factor for FY 2006 of \$12,767. Note that the FY 2006 standard payment conversion factor will be lower than it was in FY 2005 because it needs to be reduced to ensure that estimated aggregate payments for FY 2006 will remain the same as they otherwise would have been without the proposed changes. If we do not decrease the standard payment conversion factor, each of the changes we are finalizing in this final rule would increase total estimated aggregate payments by increasing payments to rural and teaching facilities, and to facilities with a higher average case mix of patients and facilities that treat a higher proportion of low-income patients. To assess how overall estimated payments to a particular type of IRF will likely be affected by any of the changes we are finalizing in this final rule, please see Table 13 of this final rule.

The FY 2006 standard payment conversion factor would be applied to each CMG relative weight shown in Table 4, Relative Weights for Case-Mix Groups, to compute the unadjusted IRF prospective payment rates for FY 2006 shown in Table 12. To further clarify, the budget neutrality factors described above will only be applied for FY 2006 and in applicable years thereafter to the extent the adjustments are updated. Therefore, for fiscal years 2006 and thereafter, we will generally use the methodology as described in §412.624(c)(3)(ii).

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

Section 1886(j)(2)(C)(i) of the Act confers broad statutory authority upon the Secretary to adjust the classification and weighting factors in order to account for relative resource use. In addition, section 1886(j)(2)(C)(ii) provides that insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregated payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years to eliminate the effect of such coding or classification changes. Similarly, section 1886(j)(3)(A)(v) of the Act confers broad statutory authority upon the Secretary to adjust the per discharge payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among IRFs. Consistent with this broad statutory authority, we proposed in the FY 2006 proposed rule (70 FR 30188) to better distribute aggregate payments among IRFs to more accurately reflect their case mix and the increased costs associated with IRFs that have teaching

programs, are located in rural areas, or treat a high proportion of low-income patients.

Furthermore, to ensure that total estimated aggregate payments to IRFs would not change with these proposed changes, we also proposed in the FY 2006 proposed rule (70 FR 30188) to apply a factor to the standard payment amount for each of the proposed changes to ensure that estimated aggregate payments in FY 2006 would not be greater or less than those that would have been made in the year without the proposed changes.

Final Decision: We did not specifically receive any comments on the description of the methodology used to implement the changes in a budget neutral manner. Therefore, we are finalizing our decision to adopt this budget neutrality factor methodology for FY 2006, with the change that we are incorporating HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) into the data we used previously to compute the budget neutrality factors. Based on RAND's analysis of FY 2003 data, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) and using the methodology described below, we will apply the budget neutrality factors to the standard payment amount for each of the changes described below to ensure that estimated aggregate payments in FY 2006 will be the same with or without the changes. We

are finalizing our decision in this final rule to calculate these four factors using the following steps:

Step 1 Determine the FY 2006 IRF PPS standard payment amount using the FY 2005 standard payment conversion factor increased by the estimated market basket of 3.6 percent (estimated for this final rule) and reduced by 1.9 percent to account for coding changes (as discussed in section VI.A of this final rule).

Step 2 Multiply the CBSA-based budget neutrality factor discussed in this preamble by the standard payment amount computed in step 1 to account for the wage index and labor-related share (0.9995), as discussed in section VI.B.2.f of this final rule.

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

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

Step 5 Divide the amount calculated in step 3 by the amount calculated in step 4 to determine the factor (0.9995) that maintains the same total estimated aggregate payments in FY 2006 with and without the changes to the tier and CMG assignments.

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

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

Step 8 Divide the amount calculated in step 6 by the amount calculated in step 7 to determine the factor (0.9961) that keeps total estimated payments in FY 2006 the same with and without the change to the rural adjustment.

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

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

Step 11 Divide the amount calculated in step 9 by the amount calculated in step 10 to determine the factor (0.9851) that maintains the same total estimated aggregate payments in FY 2006 with and without the change to the LIP adjustment.

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

Step 13 Apply the teaching status adjustment (as

discussed in section VI.B.3 of this final rule) to calculate the estimated total amount of IRF PPS payments for FY 2006.

Step 14 Divide the amount calculated in step 12 by the amount calculated in step 13 to determine the factor (0.9889) that maintains the same total estimated aggregate payments in FY 2006 with and without the teaching status adjustment.

As discussed in section VI.B.9 of this final rule, the FY 2006 IRF PPS standard payment conversion factor that accounts for the new tier and CMG assignments, the changes to the rural and the LIP adjustments, and the teaching status adjustment applies the following factors: the market basket update, the reduction of 1.9 percent to account for coding changes, the budget-neutral CBSA-based wage index and labor-related share budget neutrality factor of 0.9995, the tier and CMG changes budget neutrality factor of 0.9995, the rural adjustment budget neutrality factor of 0.9961, the LIP adjustment budget neutrality factor of 0.9851, and the teaching status adjustment budget neutrality factor of 0.9889.

Each of these budget neutrality factors lowers the standard payment amount. The budget neutrality factor for the tier and CMG changes lowers the standard payment amount from \$13,163 to \$13,156. The budget neutrality factor for the change to the rural adjustment lowers the standard

payment amount from \$13,156 to \$13,105. The budget neutrality factor for the change to the LIP adjustment lowers the standard payment amount from \$13,105 to \$12,910.

Finally, the budget neutrality factor for the teaching status adjustment lowers the standard payment amount from \$12,910 to \$12,767. As indicated previously, the standard payment conversion factor will be lowered in order to ensure that total estimated payments for FY 2006 with the changes equal total estimated payments for FY 2006 without the changes. This is because these four changes would otherwise result in an increase, on average, to total estimated aggregate payments to IRFs, because IRFs with teaching programs, IRFs located in rural areas, IRFs with higher case mix, and IRFs with higher proportions of low-income patients would receive higher payments. To maintain the same total estimated aggregate payments to all IRFs, then, we are redistributing payments among IRFs. Thus, some redistribution of payments occurs among facilities, while total estimated aggregate payments do not change. To determine how the changes we are finalizing in this final rule are estimated to affect payments among different types of facilities, please see Table 13 in this final rule.

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

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

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

Under §412.624(c)(3)(i), the standard payment conversion factor for FY 2002 of \$11,838.00 reflected the budget neutrality adjustment described in §412.624(d)(2).

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

In the FY 2006 proposed rule (70 FR 30188), we proposed to use the revised methodology in accordance with §412.624(c)(3)(ii) and as described in section VI.B.7 of the FY 2006 proposed rule (70 FR 30188) to propose an update to the standard payment conversion factor for FY 2006.

Final Decision: We did not specifically receive any comments on the proposed standard payment conversion factor for FY 2006. Therefore, we are finalizing our decision to adopt the proposed methodology for computing the standard payment conversion factor, with the change that we are incorporating HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) into the FY 2003 data we used previously to compute the final standard payment conversion factor for FY 2006. Based on RAND's analysis of FY 2003 data, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule) and using the methodology we are finalizing in section VI.B.7 and section VI.B.8 of this final rule, we will calculate the standard payment conversion factor for FY 2006 by applying the market basket increase factor (estimated for this final rule to be 3.6 percent) to the standard payment conversion factor for FY 2005 (\$12,958), which equals \$13,425. Then, we will apply a one-time reduction to the standard payment amount of 1.9 percent to adjust for coding changes that increased payment to IRFs, which equals \$13,169. We will then apply

the budget neutral wage adjustment of 0.9995 to \$13,169, which will result in a standard payment amount of \$13,163. Next, we will apply a budget neutrality factor for FY 2006 for the budget-neutral refinements to the tiers and CMGs, the teaching status adjustment, the rural adjustment, and the adjustment for the proportion of low-income patients (of 0.9699) to \$13,163, which will result in a standard payment conversion factor for FY 2006 of \$12,767. The FY 2006 standard payment conversion factor will be applied to each CMG weight shown in Table 4 of this final rule, *Relative Weights for Case-Mix Groups*, to compute the unadjusted IRF prospective payment rates for FY 2006 shown in Table 12 of this final rule.

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

To illustrate the methodology that we will use to adjust the Federal prospective payments (as described in section VI.B.7 and section VI.B.8 of this final rule), we provide an example in Table 11 below. Note that the methodology we are finalizing in this final rule has changed somewhat from the methodology we proposed in the FY 2006 proposed rule (70 FR 30188) because, upon further analysis, CMS discovered that the example used to illustrate the proposed adjustments to the Federal prospective payments in the FY 2006 proposed rule (70 FR 30188) did not calculate payments as accurately as the one we are finalizing in this

final rule. Therefore, we have made a slight adjustment to the methodology we are finalizing in this final rule to ensure that payments are calculated as accurately as possible. Accordingly, we will multiply the teaching status adjustment, if applicable, by the wage adjusted Federal payment amount, rather than by the rural and LIP adjusted Federal payment amount as we proposed in the FY 2006 proposed rule (70 FR 30188), and add the resulting amount to the FY 2006 adjusted Federal prospective payment to compute the total FY 2006 adjusted Federal prospective payment (as illustrated in the following example).

We summarize 3 examples for computing total FY 2006 adjusted federal prospective payment rates in Table 11 below. These examples are based on 3 beneficiaries classified into CMG 0110 (without comorbidities) receiving care in 3 different hypothetical IRFs. IRFs A, B, and C have the following characteristics:

- Facility A is a non-teaching IRF located in rural Duke County, Massachusetts with a disproportionate share hospital (DSH) adjustment of 5 percent (1.031) and the FY 2006 blended wage index of 1.0216;
- Facility B is a teaching IRF located in urban Queens County, New York with a disproportionate share hospital (DSH) adjustment of 10 percent (1.0612) and a FY 2006 blended wage index of 1.3449. The

teaching status adjustment of 1.0910 will also be applied; and,

- Facility C is a non-teaching IRF located in Kings County, California with a disproportionate share hospital (DSH) adjustment of 20 percent (1.1203) and a FY 2006 blended wage index of 0.9797. The Kings County, California IRF was designated as a rural facility in FY 2005 (based on the MSA designation), but is classified as urban in FY 2006 (based on the CBSA designation). Therefore, this IRF will receive a hold harmless adjustment of 12.76 percent. The hold harmless adjustment applies to IRFs that are defined as rural under §412.602 during FY 2005 and are classified as urban under §412.602 in FY 2006 (as discussed in detail in section VI.B.2.e).

To calculate each IRF's total adjusted Federal prospective payment, we compute the wage-adjusted Federal prospective payment and multiply the result by the appropriate low-income patient adjustment, and the rural adjustment (if applicable). In order to calculate the teaching hospital adjustment (if applicable), we multiply the teaching adjustment by the Wage Adjusted Federal payment. Then, we apply the amount to the Adjusted Rural and LIP Federal Prospective Payment Rate. Table 11

illustrates the components of the adjusted payment calculation.

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

	Facility A Dukes County, MA	Facility B Queens County, NY	Facility C Kings County, CA
Federal Prospective Payment	\$27,686.52	\$27,686.52	\$27,686.52
Labor Share	X 0.75865	X 0.75865	X 0.75865
Labor Portion of Federal Payment	= \$21,004.38	= \$21,004.38	= \$21,004.38
FY 2006 Transition Wage Index (shown in Tables 1 in the addendum)	X 1.0216	X 1.3449	X 0.9797
Wage-Adjusted Amount	= \$21,458.07	= \$28,248.79	= \$20,577.99
Nonlabor Amount	\$6,682.14	\$6,682.14	\$6,682.14
Wage-Adjusted Federal Payment	\$28,140.21	\$34,930.93	\$27,260.13
Rural Adjustment	X 1.2130	X 1.0000	X 1.1276
Subtotal	= \$34,134.08	= \$34,930.93	= \$30,738.52
LIP Adjustment	1.0310	1.0612	1.1203
FY 2006 Adjusted Rural and LIP Federal Prospective Payment Rate	\$35,192.24	\$37,068.70	\$34,436.37
Wage-Adjusted Federal Payment	\$28,140.21	\$34,930.93	\$27,260.13
Teaching status adjustment	X 1.0000	X 1.0900	X 1.0000
	= \$28,140.21	= \$38,074.71	= \$27,260.13
Teaching Status addition to FY 2006 Adjusted Rural and LIP Federal Prospective Payment Rate	\$0.00	\$3,143.78	\$0.00
Total FY 2006 Adjusted Federal Prospective Payment	\$35,192.24	\$40,212.49	\$34,436.37

Thus, the adjusted payment for Facility A will be \$35,192.24, the adjusted payment for Facility B will be \$40,212.49, and adjusted payment for Facility C will be \$34,436.37.

Table 12: FY 2006 Payment Rate Table Based On All Refinements				
CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	\$9,819.10	\$9,318.63	\$8,278.12	\$8,107.05
0102	\$12,091.63	\$11,476.26	\$10,194.45	\$9,983.79
0103	\$14,250.53	\$13,525.36	\$12,015.02	\$11,767.34
0104	\$15,140.39	\$14,369.26	\$12,765.72	\$12,501.45
0105	\$18,171.27	\$17,246.94	\$15,321.68	\$15,005.06
0106	\$21,151.09	\$20,074.83	\$17,834.22	\$17,465.26
0107	\$24,411.78	\$23,169.55	\$20,582.96	\$20,159.09
0108	\$28,222.73	\$26,786.44	\$23,796.41	\$23,304.88
0109	\$28,056.76	\$26,629.41	\$23,655.97	\$23,168.27
0110	\$33,528.70	\$31,823.02	\$28,269.97	\$27,686.52
0201	\$10,392.34	\$8,714.75	\$7,687.01	\$7,210.80
0202	\$13,324.92	\$11,174.96	\$9,856.12	\$9,244.58
0203	\$15,942.15	\$13,369.60	\$11,791.60	\$11,061.33
0204	\$17,051.61	\$14,300.32	\$12,612.52	\$11,831.18
0205	\$20,913.62	\$17,539.30	\$15,468.50	\$14,509.70
0206	\$27,294.57	\$22,891.23	\$20,189.73	\$18,937.29
0207	\$35,309.69	\$29,611.78	\$26,117.45	\$24,497.32
0301	\$14,417.77	\$12,174.61	\$10,775.35	\$9,912.30
0302	\$18,804.51	\$15,879.59	\$14,053.91	\$12,927.86
0303	\$22,438.00	\$18,947.50	\$16,770.73	\$15,426.37
0304	\$30,922.95	\$26,112.35	\$23,112.10	\$21,258.33
0401	\$12,627.84	\$10,873.65	\$9,774.42	\$8,728.80
0402	\$17,414.19	\$14,996.12	\$13,479.40	\$12,036.73
0403	\$30,312.69	\$26,103.41	\$23,464.47	\$20,953.20
0404	\$54,345.29	\$46,798.72	\$42,067.27	\$37,565.62
0405	\$41,463.39	\$35,705.47	\$32,094.96	\$28,660.64
0501	\$9,836.97	\$8,233.44	\$7,201.86	\$6,458.83
0502	\$13,170.44	\$11,023.03	\$9,642.92	\$8,648.37
0503	\$17,460.15	\$14,613.11	\$12,783.60	\$11,463.49
0504	\$21,857.10	\$18,292.56	\$16,002.16	\$14,350.11
0505	\$25,902.97	\$21,679.64	\$18,965.38	\$17,006.92
0506	\$35,245.86	\$29,499.43	\$25,804.66	\$23,141.46

Table 12: FY 2006 Payment Rate Table Based On All Refinements				
CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0601	\$11,445.62	\$9,359.49	\$8,893.49	\$8,289.61
0602	\$15,224.65	\$12,450.38	\$11,831.18	\$11,025.58
0603	\$19,490.10	\$15,938.32	\$15,145.49	\$14,115.20
0604	\$24,945.44	\$20,400.39	\$19,384.14	\$18,066.58
0701	\$11,560.52	\$9,876.55	\$9,275.23	\$8,407.07
0702	\$15,010.16	\$12,823.17	\$12,041.83	\$10,914.51
0703	\$18,685.78	\$15,963.86	\$14,991.01	\$13,587.92
0704	\$22,932.09	\$19,590.96	\$18,397.25	\$16,676.26
0801	\$8,376.43	\$7,035.89	\$6,522.66	\$5,867.71
0802	\$10,941.32	\$9,189.69	\$8,519.42	\$7,665.31
0803	\$16,223.03	\$13,624.94	\$12,631.67	\$11,363.91
0804	\$14,131.79	\$11,868.20	\$11,002.60	\$9,899.53
0805	\$17,793.37	\$14,943.77	\$13,854.75	\$12,464.42
0806	\$21,354.08	\$17,933.80	\$16,626.46	\$14,957.82
0901	\$10,739.60	\$9,776.97	\$8,687.94	\$7,775.10
0902	\$14,112.64	\$12,847.43	\$11,416.25	\$10,216.15
0903	\$18,618.12	\$16,949.47	\$15,061.23	\$13,478.12
0904	\$23,339.35	\$21,248.12	\$18,879.84	\$16,895.85
1001	\$12,304.83	\$11,347.31	\$10,125.51	\$9,335.23
1002	\$16,225.58	\$14,961.65	\$13,350.45	\$12,308.66
1003	\$22,822.29	\$21,043.85	\$18,778.98	\$17,313.33
1101	\$16,014.92	\$13,400.24	\$11,731.60	\$10,803.44
1102	\$23,976.43	\$20,060.79	\$17,562.29	\$16,173.24
1201	\$13,001.91	\$11,227.30	\$10,348.93	\$9,341.61
1202	\$16,828.18	\$14,532.68	\$13,395.14	\$12,090.35
1203	\$20,731.05	\$17,901.89	\$16,501.35	\$14,893.98
1301	\$13,198.52	\$12,278.02	\$10,628.53	\$9,393.96
1302	\$18,287.45	\$17,012.03	\$14,725.46	\$13,015.96
1303	\$23,373.82	\$21,744.75	\$18,822.39	\$16,637.95
1401	\$10,433.19	\$9,386.30	\$8,165.77	\$7,412.52
1402	\$14,087.11	\$12,672.52	\$11,025.58	\$10,008.05
1403	\$17,535.47	\$15,774.91	\$13,724.53	\$12,459.32
1404	\$22,238.84	\$20,007.17	\$17,405.25	\$15,800.44
1501	\$11,773.73	\$11,483.92	\$9,813.99	\$9,443.75

Table 12: FY 2006 Payment Rate Table Based On All Refinements				
CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1502	\$14,885.05	\$14,517.36	\$12,406.97	\$11,939.70
1503	\$18,217.23	\$17,767.83	\$15,185.07	\$14,611.83
1504	\$24,017.28	\$23,424.89	\$20,019.93	\$19,264.13
1601	\$12,849.99	\$10,908.12	\$9,870.17	\$8,814.34
1602	\$17,631.23	\$14,968.03	\$13,541.96	\$12,094.18
1603	\$21,688.58	\$18,411.29	\$16,658.38	\$14,877.39
1701	\$12,897.22	\$12,299.73	\$10,625.97	\$9,346.72
1702	\$16,986.49	\$16,198.77	\$13,995.19	\$12,311.22
1703	\$20,212.71	\$19,275.62	\$16,652.00	\$14,648.86
1704	\$25,288.87	\$24,115.59	\$20,834.47	\$18,327.03
1801	\$15,471.05	\$12,552.51	\$10,526.39	\$9,296.93
1802	\$24,748.83	\$20,079.94	\$16,839.67	\$14,872.28
1803	\$44,408.73	\$36,031.03	\$30,216.94	\$26,686.86
1901	\$15,782.57	\$14,019.44	\$13,631.33	\$11,935.87
1902	\$29,570.93	\$26,266.83	\$25,539.11	\$22,361.40
1903	\$42,691.57	\$37,921.82	\$36,872.37	\$32,283.91
2001	\$11,162.19	\$9,430.98	\$8,455.58	\$7,720.20
2002	\$14,615.66	\$12,348.24	\$11,070.27	\$10,107.63
2003	\$18,881.12	\$15,952.37	\$14,301.59	\$13,056.81
2004	\$25,222.49	\$21,310.68	\$19,104.54	\$17,443.55
2101	\$27,906.11	\$27,906.11	\$20,312.30	\$18,846.65
5001	\$0.00	\$0.00	\$0.00	\$2,810.02
5101	\$0.00	\$0.00	\$0.00	\$8,108.32
5102	\$0.00	\$0.00	\$0.00	\$20,429.75
5103	\$0.00	\$0.00	\$0.00	\$9,197.35
5104	\$0.00	\$0.00	\$0.00	\$23,964.94

VII. Quality of Care in IRFs

The IRF-PAI is the patient data collection instrument for IRFs. Currently, the IRF-PAI contains a blend of the functional independence measures items and quality and

medical needs questions. The quality and medical needs questions (which are currently collected on a voluntary basis) may need to be modified to encapsulate those data necessary for calculation of quality indicators in the future.

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

Once RTI has issued a final report, taking into account and responding to public comments in the **Federal Register** as part of the Paperwork Reduction Act process, we will publish our rationale for revising the IRF-PAI. Then in accordance with the Paperwork Reduction Act, we will publish our proposed revisions to the IRF-PAI and solicit public comments. The revised IRF-PAI will need to be approved by OMB before it is used in IRFs.

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

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

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

services that focuses on the overall post-acute episode.

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

In order to accomplish this objective, we need to collect and compare clinical data across different sites of service.

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

appropriate to explore additional options for paying for post-acute services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods, including the IRF PPS.

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

It is important to note that some of the ideas discussed above may exceed our current statutory authority.

However, we believe that it is useful to encourage discussion of a broad range of ideas for debate of the relative advantages and disadvantages of the various policies affecting this important component of the health care sector. Thus, we solicited comments on these and other

approaches.

Comment: Most commenters were supportive of the concept of providing incentives for high quality and improved patient outcomes within the structure of Medicare's payment systems. Commenters were also generally supportive of advancing approaches that resulted in more consistent payments for similar services across the various post acute care settings and a more seamless system of care, though several noted important distinctions between the type of care provided in IRF compared to other settings. For example, one commenter objected to the implication that the differentiation among provider types (such as SNFs and IRFs) could become less pronounced. This commenter stated that there is a big difference in care and rehabilitation between these two types of facilities and suggested that we ask patients about this difference. Many Commenters noted that, in advancing these policy goals, CMS should facilitate stakeholder input to ensure that the knowledge and experience of providers, beneficiaries, and others with critical knowledge is factored into the development process.

Response: CMS appreciates the thoughtful comments provided on these important issues. By advancing a more seamless system of payments and benefits in post acute care, Medicare can ensure that patients receive high quality care in the most appropriate setting, and that decisions about

where patients receive care are guided by decisions of patients and their families working with physicians, rather than in response to financial incentives or barriers created by administrative guidelines. In addition, pay for performance has the potential to promote real improvements in quality and outcomes as demonstrated by the work CMS has advanced already; for example, the Premier Hospital Demonstration.

We agree with commenters that CMS should involve stakeholders and work collaboratively with providers, patients and practitioners in the field to advance these objectives. In developing additional IRF-PAI quality items and related quality measures through our research with RTI, as described in section VII above, RTI has already begun to do that by convening meetings of a Technical Expert Panel to consider the critical methodological and clinical issues. The research we are conducting through the RTI contract will provide data that will promote and advance efforts to develop and consider pay for performance approaches in IRFs, as well as approaches to measuring and rewarding quality improvement more broadly in post acute care. We also agree that, in developing a more integrated strategy for payment and care delivery within Medicare's post acute benefits, it will be important to consider not only how various provider types are similar but also how they are different.

VIII. Miscellaneous Public Comments Within the Scope of the Proposed Rule

Comment: We received a comment regarding a change made to §412.25(a) when the inpatient psychiatric facility (IPF) PPS was published on November 15, 2004 (69 FR 66922). The commenter requested that we add the reference to a rehabilitation unit that was removed by the IPF PPS final rule.

Response: We agree with making the change requested by the commenter. Section 412.1 specifies the scope of part 412. In order to expand the existing scope of part 412 the IPF PPS final rule revised §412.1 by redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4) and adding a new paragraph (a)(2). The added paragraph (a)(2) specified that in accordance with section 124 of Pub. L. 106-113 we were establishing a per diem prospective payment system for the inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N of part 412. Redesignated as paragraph (a)(3) is the paragraph that specifies the statutory basis for the establishment of the IRF PPS.

In order to conform §412.25(a) to the revision we made as stipulated above to §412.1 the IPF PPS final rule revised §412.25(a), which specifies the basis for exclusion from

being paid under the IPPS. Prior to publishing the IPF PPS final rule, §412.25(a) read as follows:

(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.

When the IPF PPS final rule revised §412.25(a) the intended purpose of the revision was to include a reference to new paragraph (a)(2) that, as stipulated above, we had added to §412.1. However, when we revised §412.25(a), we inadvertently removed the words "or rehabilitation" from the existing §412.25(a). Therefore, in order to correct the inadvertent removal of the words "or rehabilitation" from §412.25(a), we are making a technical correction so that §412.25(a) will read as follows:

(a) Basis for exclusion. In order to be excluded from the prospective payment systems as specified in §412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in §412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in §412.1(a)(3), a psychiatric or rehabilitation unit must meet the following requirements.

IX. Miscellaneous Publics Comments Outside the Scope of the Proposed Rule

Comment: We received a number of comments expressing concerns about various aspects of CMS's enforcement of the 75 percent rule. Several commenters stated that enforcement of the 75 percent rule would lead many IRFs to close, would arbitrarily exclude patients in certain RICs from receiving treatment in IRFs, and would create access to care problems for patients.

Response: These comments are not specifically related to the proposed changes to the IRF PPS that were discussed in the FY 2006 proposed rule (70 FR 30188). We responded to similar comments in the May 7, 2004 final rule (69 FR 25752) that established the changes to the criteria for being classified as an IRF. Because the responses to these comments in the May 7, 2004 final rule are very lengthy, we refer the reader to that final rule for the detailed responses to these and other comments regarding the 75 percent rule.

Comment: One commenter asked that we provide the algorithm (that is, the computer software) that the fiscal intermediaries use in their presumptive determinations of IRF compliance with the 75 percent rule.

Response: We will take this into consideration, and may make the computer software available to all interested parties at a future date.

Comment: One commenter suggested that CMS consider implementing a cost-of-living adjustment for IRFs located in Alaska, to offset higher non-labor costs in Alaska.

Response: In the August 7, 2001 final rule (66 FR 41316, 41361), we referred to Section 1886(j)(4)(B), which authorizes, but does not require, the Secretary to take into account the unique circumstances of IRFs located in Alaska and Hawaii. In the data used to prepare the August 7, 2001 final rule, there was only one IRF in Hawaii and one in Alaska. In the August 7, 2001 final rule, we explained that, due to the small number of IRFs in Alaska and Hawaii in the data, analyses were inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we did not implement an adjustment for facilities located in Alaska and Hawaii in the August 7, 2001 final rule.

In the FY 2003 data used for the FY 2006 proposed rule (70 FR 30188) and for this final rule, there were 3 IRFs in Alaska and 1 IRF in Hawaii. We continue to believe that this may be too small a number of facilities for us to determine, based on analysis of the data, whether a cost-of-living adjustment would improve payment equity for these

facilities. However, we will consider conducting such an analysis in the future.

Comment: Some commenters suggested changes to the items on the IRF-PAI, such as deleting the transfer to tub item and revising the instructions for the items that describe preventable conditions that occur on admission to the IRF and preventable conditions that occur while the patient is in an IRF.

Response: We have contracted with the Research Triangle Institute (RTI) to analyze and recommend changes to the IRF-PAI that would improve our ability to assess quality of care in IRFs. Any changes to the IRF-PAI that CMS might decide to propose in the future, based on RTI's recommendations, would require clearance by the Office of Management and Budget. However, we will take the commenters suggestions into consideration.

Comment: Several commenters suggested that CMS allow general hospitals to increase physiatrist training if they also decrease training in one or more specialties reimbursed under the inpatient PPS.

Response: This comment does not relate to the IRF PPS and is outside the scope of this rule. We will forward it to the component of the Agency that works on the IPPS for their consideration.

IX. Provisions of the Final Regulations

The provisions of this final rule restate the provisions of the FY 2006 proposed rule (70 FR 30188), except as noted elsewhere in the preamble. Following is a highlight of the changes we made from the proposed rule:

- We are adding 2 codes that were not on the proposed list of ICD-9-CM codes to be removed from the comorbidity tiers (V46.11 and V46.12). We are adding these codes to the list to be removed because these codes are derived from code V46.1, which was determined by RAND to have no positive impact on payment when controlling for the CMG.
- We are adding the following codes to the list of comorbidities we proposed in the proposed rule: 250.1 (insulin dependent diabetes without mention of complications, not stated as controlled), code 428.1-Left Heart Failure, code 428.20-Systolic Heart Failure Unspecified, code 428.21-Systolic Heart Failure Acute, code 428.22-Systolic Heart Failure Chronic, code 428.23-Systolic Heart Failure Acute on Chronic, code 428.30-Diastolic Heart Failure Unspecified, code 428.31-Diastolic Heart Failure Acute, code 428.32-Diastolic Heart Failure Chronic, code 428.33-Diastolic Heart Failure Acute on Chronic, code 428.40-Combined Systolic and Diastolic Heart Failure Unspecified, code 428.41-

Combined Systolic and Diastolic Heart Failure Acute, code 428.42-Combined Systolic and Diastolic Heart Failure Chronic, and code 428.43-Combined Systolic and Diastolic Heart Failure Acute on Chronic. For this final rule, we decided to add these codes to the list of comorbidities we proposed in the proposed rule because of the increased costs associated with these codes. After receiving the comments to add additional codes to the list of comorbidity codes used to increase the CMG payment rate, our Medical Officers, similar to RAND's TEP, believe that several of the codes suggested should be added to these tiers that increase payment for the CMG.

- We are updating the market basket estimate, based on the FY 2002-based RPL market basket and the Global Insight's 2nd quarter 2005 forecast, to 3.6 percent (from 3.1 percent in the proposed rule).
- We are changing our proposed policy to adopt the CBSA-based wage index without a transition to implementing the CBSA-based wage index with a budget neutral one-year blended wage index. Thus, the FY 2006 wage index is comprised of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both based

on FY 2001 hospital wage data) for all IRFs.

- We are changing our proposed policy to not adopt a hold harmless policy to adopting a budget neutral 3 year hold harmless policy for FY 2005 rural IRFs that will be classified as urban under the FY 2006 CBSA-based designations. The 3 year hold harmless policy will only apply to existing rural FY 2005 IRFs that will experience a decrease in payments due solely to the loss of the FY 2005 rural adjustment of 19.14 percent because of the adoption of the CBSA-based designations.
- We are changing the exponent for the teaching status adjustment formula to 0.9012 (from 1.083 in the proposed rule), based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule).
- We are changing the rural adjustment to 21.3 percent (from 24.1 percent in the proposed rule), based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule).
- We are changing the exponent for the LIP

adjustment formula to 0.6229 (from 0.636 in the proposed rule), based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule).

- We are changing the outlier threshold amount to \$5,132 (from \$4,911 in the proposed rule), based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule).
- We are changing the base period for determining an IRF's FTE resident cap from the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003, which was what we had proposed in the FY 2006 proposed rule, to the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004.
- We are changing the budget neutrality factors applied to the standard payment amount in the methodology used to implement the changes in a budget neutral manner (section VI.B.8 of this final rule) to 0.9995 for the changes to the tier

comorbidities and the CMGs, 0.9961 for the change to the rural adjustment, 0.9851 for the change to the LIP adjustment, and 0.9889 for the implementation of the new teaching status adjustment. These changes are necessary to ensure that the tier and CMG changes, the rural adjustment change, the LIP adjustment change, and the implementation of the new teaching status adjustment will be done in a budget neutral manner for FY 2006 (that is, such that estimated aggregate IRF payments for FY 2006 with the changes will equal estimated aggregate IRF payment in FY 2006 without the changes).

- We are changing the budget neutrality factor for the wage index changes for FY 2006 to 0.9995, to ensure that the wage index changes described in section VI.B.2 of this final rule will be made in a budget neutral manner.
- We are changing the standard payment conversion factor for FY 2006 to \$12,767 (from \$12,658 in the proposed rule), based on RAND's most recent cost regressions using data from FY 2003, including the HealthSouth home office cost data from FY 2004 (as described in detail in section IV of this final rule).

X. Collection of Information Requirements

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

XI. Regulatory Impact Analysis**A. Introduction**

The August 7, 2001 final rule established the IRF PPS for the payment of Medicare services for cost reporting periods beginning on or after January 1, 2002. We incorporated a number of elements into the IRF PPS, such as case-level adjustments, a wage adjustment, an adjustment for the percentage of low-income patients, a rural adjustment, and an outlier payment policy. This final rule updates the FY 2005 IRF PPS payment rates specified in the July 30, 2004 notice (69 FR 45721) and implements policy changes with regard to the IRF PPS based on analyses conducted by RAND under contract with us on CY 2002 and FY 2003 data (updated from the 1999 data used to design the IRF PPS).

In constructing these impacts, we do not attempt to predict behavioral responses, nor do we make adjustments for future changes in such variables as discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting

errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, or new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) and Impact on Small Hospitals (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental,

public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).

We estimate that the cost to the Medicare program for IRF services in FY 2006 will increase by \$210 million over FY 2005 levels. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. We are making changes to the CMGs and the tiers, the teaching status adjustment, and the rural and LIP adjustments in a budget neutral manner (that is, in order that total estimated aggregate payments with the changes equal total estimated aggregate payments without the changes). This means that we are improving the distribution of payments among facilities depending on the mix of patients they treat, their teaching status, their geographic location (rural vs. urban), and the percentage of low-income patients they treat, without changing total estimated aggregate payments. To redistribute payments among facilities, we lowered the base payment amount, which then gets adjusted upward for each facility according to the facility's characteristics. This redistribution will not, however, affect estimated aggregate payments to facilities. Thus, the changes to the IRF labor-related share and the wage indices, the changes to the CMGs, the tiers, and the motor

score index, the teaching status adjustment, the update to the rural adjustment, and the update to the LIP adjustment have no overall effect on estimated costs to the Medicare program. Therefore, the estimated increased cost to the Medicare program is due to the combined effect of the updated IRF market basket of 3.6 percent, the 1.9 percent reduction to the standard payment conversion factor to account for changes in coding that affect total aggregate payments, and the update to the outlier threshold amount. We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 3.4 percent increase), we estimate that the total impact of these changes for estimated FY 2006 payments compared to estimated FY 2005 payments will be approximately a \$210 million increase. This amount does not reflect changes in IRF admissions or case-mix intensity, which also may affect the overall estimated change in payments from FY 2005 to FY 2006.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze the economic impact of our regulations on small entities. If we determine that the regulation will impose a significant burden on a substantial number of small entities, we must examine options for reducing the burden. For purposes of

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

3. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with

fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions that we are adopting, we will no longer employ NECMAs to define urban areas in New England. Therefore, for purposes of this analysis, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA).

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

4. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any final rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least \$110 million. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

5. Executive Order 13132

Executive Order 13132 establishes certain requirements

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

6. Overall Impact

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

B. Anticipated Effects of the Final Rule

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

1. Basis and Methodology of Estimates

In this final rule, we are implementing policy changes and payment rate updates for the IRF PPS. Based on the overall percentage change in payments per discharge estimated using a payment simulation model developed by RAND

under contract with CMS (a 3.4 percent increase), we estimate the total impact of these changes for estimated FY 2006 payments compared to estimated FY 2005 payments to be approximately a \$210 million increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which also may affect the overall change in payments from FY 2005 to FY 2006.

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

The data used in developing the quantitative analyses of estimated changes in payments per discharge presented below are taken from the FY 2003 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Data from the most recently available IRF cost reports were used to estimate costs and to categorize hospitals. The data also include the FY 2004 home office costs for HealthSouth facilities, as described in section IV of the preamble to this final rule.

Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the policy changes, and we do not adjust for future changes in such variables as admissions,

lengths of stay, or case-mix. Second, due to the interdependent nature of the IRF PPS payment components, it is very difficult to precisely quantify the impact associated with each change.

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

The changes discussed separately below are the following:

- The effects of the annual market basket update (using the rehabilitation hospital, psychiatric hospital, and long-term care hospital (RPL) market basket) to IRF PPS payment rates required by sections 1886(j)(3)(A)(i) and 1886(j)(3)(C) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the decrease to the standard payment amount to account for the increase in estimated aggregate payments due to changes in coding, as required under section 1886(j)(2)(C)(ii) of the Act.
- The effects of the budget-neutral changes to the tier comorbidities, CMGs, motor score index, and

relative weights, under the authority of section 1886(j) (2) (C) (i) of the Act.

- The effects of the one year budget-neutral transition policy for adopting the new CBSA-based geographic area definitions announced by OMB in June 2003.
- The effects of the 3 year budget-neutral hold-harmless policy for IRFs that are rural under \$412.602 during FY 2005, but are urban under \$412.602 during FY 2006 and lose the rural adjustment resulting in a loss of estimated IRF PPS payments and meets the intent of the hold harmless policy.
- The effects of the implementation of a budget-neutral teaching status adjustment, as permitted under section 1886(j) (3) (A) (v) of the Act.
- The effects of the budget-neutral update to the percentage amount by which payments are adjusted for IRFs located in rural areas, as permitted under section 1886(j) (3) (A) (v) of the Act.
- The effects of the budget-neutral update to the formula used to calculate the payment adjustment for IRFs based on the percentage of low-income patients they treat, as permitted under section 1886(j) (3) (A) (v) of the Act.

- The effects of the change to the outlier loss threshold amount to maintain total estimated outlier payments at 3 percent of total estimated payments to IRFs in FY 2006, consistent with section 1886(j)(4) of the Act.
- The total change in estimated payments based on the FY 2006 policies relative to estimated payments based on FY 2005 policies.

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

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

total estimated payments.

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

2. Analysis of Table 13

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

profit, and government), and by teaching status. The top row of the table shows the overall impact on the 1,188 IRFs included in the analysis.

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

The following three parts of Table 13 show IRFs grouped by their geographic location within a region, and the last

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

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

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	FY06 Wage Index and Labor-share (4)	Outlier (5)	Market Basket (6)	New CMG, New Tiers, and Motor Score (7)	Rural Adjust. (8)	New LIP Adjust. (9)	Teach. Status Adjust. (10)	1.9% Reduct. (11)	Total % Change (12)
New England	35	20,612	-0.3%	1.7%	3.6%	-0.7%	-0.3%	-0.3%	-0.6%	-1.9%	1.1%
Middle Atlantic	156	76,962	-0.4%	2.0%	3.6%	1.1%	-0.2%	0.0%	1.6%	-1.9%	5.8%
South Atlantic	124	73,677	0.4%	0.6%	3.6%	-0.5%	0.1%	0.0%	-0.3%	-1.9%	1.9%
East North Central	189	69,315	0.1%	2.3%	3.6%	1.2%	-0.2%	-0.2%	0.1%	-1.9%	4.9%
East South Central	54	30,473	0.2%	0.0%	3.6%	-1.4%	0.4%	0.1%	-0.5%	-1.9%	0.6%
West North Central	71	22,217	-0.1%	2.1%	3.6%	0.6%	-0.2%	-0.1%	0.1%	-1.9%	4.2%
West South Central	184	76,088	0.5%	1.8%	3.6%	-0.7%	-0.3%	-0.1%	-0.5%	-1.9%	2.3%
Mountain	69	24,287	-0.2%	1.2%	3.6%	-2.2%	-0.1%	-0.1%	-0.5%	-1.9%	-0.2%
Pacific	116	26,566	0.8%	2.2%	3.6%	-0.8%	-0.3%	1.1%	0.0%	-1.9%	4.7%
Rural by region											
New England	4	924	0.4%	2.1%	3.6%	1.7%	1.2%	-0.4%	-0.9%	-1.9%	5.9%
Middle Atlantic	19	5,377	-1.1%	8.2%	3.6%	1.5%	1.4%	-0.4%	-1.0%	-1.9%	10.3%
South Atlantic	22	5,440	-1.0%	2.5%	3.6%	1.2%	1.3%	0.1%	-1.0%	-1.9%	4.8%
East North Central	28	5,618	-1.0%	3.0%	3.6%	1.9%	1.2%	-0.4%	-0.9%	-1.9%	5.5%

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

Facility Classification (1)	Number of IRFs (2)	Number of cases (3)	FY06 Wage Index and Labor-share (4)	Outlier (5)	Market Basket (6)	New CMG, New Tiers, and Motor Score (7)	Rural Adjust. (8)	New LIP Adjust. (9)	Teach. Status Adjust. (10)	1.9% Reduct. (11)	Total % Change (12)
East South Central	20	5,362	-1.9%	2.2%	3.6%	1.1%	1.3%	0.3%	-0.7%	-1.9%	3.9%
West North Central	30	5,351	-1.3%	2.3%	3.6%	2.7%	1.2%	-0.2%	-0.6%	-1.9%	5.8%
West South Central	54	12,016	-1.7%	4.3%	3.6%	0.3%	1.3%	0.1%	-1.0%	-1.9%	4.9%
Mountain	9	902	-3.2%	9.4%	3.6%	2.6%	1.2%	-0.4%	-0.9%	-1.9%	10.2%
Pacific	4	551	0.9%	2.8%	3.6%	-2.7%	1.1%	-0.8%	-0.8%	-1.9%	2.0%
Teaching Status											
Non-teaching	1,053	400,072	0.0%	1.6%	3.6%	-0.1%	0.0%	-0.1%	-0.9%	-1.9%	2.2%
Resident to ADC less than 10%	71	39,888	0.3%	2.5%	3.6%	0.3%	-0.3%	0.2%	2.2%	-1.9%	7.0%
Resident to ADC 10%-19%	42	17,793	-0.9%	2.8%	3.6%	0.4%	-0.3%	1.1%	9.1%	-1.9%	14.3%
Resident to ADC greater than 19%	22	3,985	-0.1%	4.1%	3.6%	0.0%	-0.3%	1.1%	19.5%	-1.9%	27.4%

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

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

As discussed in detail in section VI.B.1 of this final rule, we are using a new market basket that reflects the operating and capital cost structures of inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, referred to as the RPL market basket. The FY 2006 update for IRF PPS payments using the FY 2002-based RPL market basket and the Global Insight's 2nd quarter 2005 forecast will be 3.6 percent.

In the aggregate, and across all hospital groups, the update will result in a 3.6 percent increase in overall estimated payments to IRFs.

4. Impact of the 1.9 Percent Decrease in the Standard Payment Amount to Account for Coding Changes (Column 11)

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

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

5. Impact of the Changes to the CMGs and Tiers and Recalibration of Relative Weights (Column 7)

In column 7 of Table 13, we present the estimated effects of the changes to the tier comorbidities, the CMGs, the motor score index, and the recalibration of the relative

weights, as discussed in section V of this final rule. Section 1886(j)(2)(C)(i) of the Act requires us to adjust from time to time the classifications and weighting factors as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment under the IRF PPS is made, and any other factors which may affect the relative use of resources.

As described in section V.A.3 of this final rule, we are updating the tier comorbidities to remove certain comorbid condition codes from the list of comorbid conditions used to increase payment that we believe no longer merit additional payments, moving dialysis patients to tier one to increase payments for these patients, and aligning payments with the comorbidity conditions according to their effects on the relative costliness of patients. We are also updating the CMGs and the relative weights for the CMGs so that they better reflect the relative costliness of different types of IRF patients. We are also replacing the previous, unweighted motor score index with a weighted motor score index that better estimates the relative costliness of IRF patients. Finally, we are changing the GROUPER software so that, in cases where the provider has coded a 0 for the transfer to toilet item on the IRF-PAI, the GROUPER will change this raw score of 0 to a 2 instead of a 1.

To assess the impact of these changes, we compared estimated aggregate payments using the FY 2005 CMG relative weights (GROUPER version 1.22) to estimated aggregate payments using the FY 2006 CMG relative weights (GROUPER version 1.30). We note that, under the authority in section 1886(j)(2)(C)(i) of the Act and consistent with our rationale as described in section VI.B.8 of this final rule, we have applied a budget neutrality factor to ensure that the overall estimated payment impact of the tier and CMG changes is budget neutral (that is, in order that total estimated aggregate payments for FY 2006 with the change are equal to total estimated aggregate payment for FY 2006 without the change). Because we found that the relative weights we will use for calculating the FY 2006 payment rates are slightly higher, on average, than the relative weights we used in FY 2005, and that the effect of this would have been to increase estimated aggregate payments in FY 2006, the budget neutrality factor for the CMG and tier changes lowers the standard payment amount somewhat. Because the lower standard payment amount is balanced by the higher average weights, the effect is no change in overall estimated payments to IRFs. However, the distribution of estimated payments among facilities is affected, with some facilities receiving higher estimated payments and some

facilities receiving lower estimated payments as a result of the tier and CMG changes, as shown in column 7 of Table 13.

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

6. Impact of the Adoption (With a Blended One-Year Transition) of the New CBSA Labor Market Areas and the Changes to the Labor Share (Column 4)

In accordance with the broad discretion under section 1886(j)(6) of the Act, we previously defined hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by OMB as discussed in section VI.B.2 of this final rule. On June 6, 2003, OMB announced new Core-Based Statistical Areas (CBSAs), comprised of MSAs and the new Micropolitan

Statistical Areas based on Census 2000 data. We are adopting the new CBSA definitions with a one-year blended transition as described in section VI.B.2 of this final rule, consistent with the inpatient prospective payment system, including the 49 new Metropolitan areas designated under the new definitions. We are also adopting CBSA definitions in New England in place of NECMAs. We are not adopting the newly defined Micropolitan Statistical Areas for use in the payment system, as Micropolitan Statistical Areas will remain part of the statewide rural areas for purposes of the IRF PPS payments, consistent with payments under the inpatient prospective payment system.

The estimated effects of these changes to the new CBSA-based designations with a one year blended transition, combined with the new labor share, are isolated in column 4 of Table 13 by holding all other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in estimated payments when going from a model using the FY 2005 MSA designations to a model using the FY 2006 CBSA designations blended with the FY 2006 MSA designations and using the new labor share. As described in section VI.B.2 of this final rule, we are implementing a blended wage index for FY 2006 equal to 50 percent of the FY 2006 CBSA wage index value and 50 percent of the FY 2006 MSA wage

index value for all IRFs for one year. The estimated effects of this policy are shown in column 4 of table 13.

Table 14 below compares the shifts in wage index values for IRFs for FY 2006 relative to FY 2005. A small number of IRFs (0.9 percent) will experience an increase of between 5 and 10 percent and 0.6 percent of IRFs will experience an increase of more than 10 percent. A small number of IRFs (0.6 percent) will experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Furthermore, IRFs that will experience decreases in their wage index values of greater than 10 percent will be 0.1 percent.

The following table shows the projected impact for IRFs.

Table 14 -Impact of the FY 2006 Blended Transition Wage Index	
Percent Change in Area Wage Index	Percent of IRFs
Decrease Greater Than 10.0	0.1%
Decrease Between 5.0 and 10.0	0.6%
Decrease Between 2.0 and 5.0	2.7%
Decrease Between 0 and 2.0	31.0%
No Change	37.2%
Increase Between 0 and 2.0	24.5%
Increase Between 2.0 and 5.0	2.4%
Increase Between 5.0 and 10.0	0.9%
Increase Greater Than 10.0	0.6%
Total ¹	100.0%

^{1/} May not exactly equal 100 percent due to rounding.

In addition, our analysis file consisted of 34 rural IRFs that change designations from a rural facility (under the MSA-based designations) to an urban facility (under the CBSA-based designations) and would experience estimated payment reductions due to the loss of the 19.14 percent rural adjustment. Based on our analysis, these IRFs would experience a reduction in estimated payments of between approximately \$207 to up to approximately \$3,070 (average amount of approximately \$1,472) without a hold harmless policy.

Based on our estimates, the hold harmless policy would mitigate the estimated payment reductions of those rural IRFs in our analysis file. Although, we found that 5 IRFs would experience estimated payment increases under the hold harmless policy of between approximately \$9 to approximately \$380, these IRFs will not receive additional payments under the hold harmless policy. The remaining 29 rural IRFs under our hold harmless policy can expect estimated payment reductions of between approximately \$32 to approximately \$1,167 (average amount of approximately \$426) in FY 2006 compared to our estimates above.

7. Impact of the Change to the Outlier Threshold Amount (Column 5)

We estimate total outlier payments in FY 2005 to be

approximately 1.2 percent of total estimated payments, so we are updating the threshold from \$11,211 in FY 2005 to \$5,132 in FY 2006 in order to set total estimated outlier payments in FY 2006 equal to 3 percent of total estimated payments in FY 2006.

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

The effect on payments to rural IRFs will be to increase estimated payments by 3.8 percent, and the effect on payments to urban IRFs will be to increase estimated payments by 1.6 percent. The largest effect will be a 9.4 percent increase in estimated payments to rural IRFs in the Mountain region, and the smallest effect will be no change in estimated payments for urban IRFs located in the East South Central region.

8. Impact of the Budget-Neutral Teaching Status Adjustment (Column 10)

In column 10 of Table 13, we present the estimated effects of the budget-neutral implementation of a teaching status adjustment to the Federal prospective payment rate for IRFs that have teaching programs, as discussed in section VI.B.3 of this final rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal

prospective payment rates for IRFs under the IRF PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under the authority of section 1886 (j) (3) (A) (v) of the Act, we are applying a budget neutrality factor to ensure that the overall estimated payment impact of the teaching status adjustment is budget neutral (that is, in order that total estimated aggregate payments for FY 2006 with the adjustment will equal total estimated aggregate payments for FY 2006 without the adjustment). Because IRFs with teaching programs will receive additional payments from the implementation of this new teaching status adjustment, the effect of the budget neutrality factor will be to reduce the standard payment amount, therefore reducing estimated payments to IRFs without teaching programs. By design, however, the estimated increases in payments to teaching facilities will balance the estimated decreases in payments to non-teaching facilities, and total estimated aggregate payments to all IRFs will remain unchanged. Therefore, the first row of column 10 of Table 13 contains our projection of a zero impact in the aggregate. However, the rest of column 10 gives the estimated distributional effects among different types of providers of this change. Some providers'

estimated payments increase and some decrease with this change.

On average, the estimated impacts of this change on any particular group of IRFs are very small, with urban IRFs experiencing a 0.1 percent estimated increase and rural IRFs experiencing a 0.9 percent estimated decrease.

The largest decrease in estimated payments is a 1.0 percent decrease among freestanding rural IRFs, rural for-profit facilities, rural government-owned facilities, and rural facilities in the Middle Atlantic, South Atlantic, and West South Central regions.

Overall, non-teaching hospitals will experience a 0.9 percent estimated decrease. The largest impacts are a 19.5 percent estimated increase among teaching facilities with intern and resident to ADC ratios greater than 19 percent. Teaching facilities that have intern and resident to ADC ratios greater than or equal to 10 percent and less than or equal to 19 percent will experience an estimated increase of 9.1 percent. Teaching facilities with resident and intern to ADC ratios less than 10 percent will experience an estimated increase of 2.2 percent.

9. Impact of the Update to the Rural Adjustment (Column 8)

In column 8 of Table 13, we present the estimated effects of the budget-neutral update to the percentage

adjustment to the Federal prospective payment rates for IRFs located in rural areas, as discussed in section VI.B.4 of this final rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal prospective payment rates for IRFs under the IRF PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In accordance with section 1886(j)(3)(A)(v) of the Act, we are changing the rural adjustment percentage, based on FY 2003 data with an adjustment to account for the absence of HealthSouth home office costs in that year (see the discussion in section IV of the preamble to this final rule), from 19.14 percent to 21.3 percent.

Because we are making this update to the rural adjustment in a budget neutral manner under the broad authority conferred by section 1886(j)(3)(A)(v) of the Act, estimated payments to urban facilities will decrease in proportion to the total increase in estimated payments to rural facilities. To accomplish this estimated redistribution of resources between urban and rural facilities, we applied a budget neutrality factor to reduce the standard payment amount. Rural facilities will receive an increase to the standard payment amount, and urban

facilities will not. Overall, estimated aggregate payments to IRFs will not change, as indicated by the zero impact we project in the first row of column 8. However, estimated payments will be redistributed among rural and urban IRFs, as indicated by the rest of the column. On average, because there are a relatively small number of rural facilities, the estimated impacts of this change on urban IRFs are relatively small, with all urban IRFs experiencing a 0.1 percent estimated decrease. The estimated impact on rural IRFs is somewhat larger, with rural IRFs experiencing a 1.3 percent estimated increase. The largest estimated impacts are a 1.4 percent estimated increase among rural IRFs in the Middle Atlantic region and a 0.3 percent estimated decrease among urban facilities in the New England, West South Central, and Pacific regions, and among all categories of teaching facilities.

10. Impact of the Update to the LIP Adjustment (Column 9)

In column 9 of Table 13, we present the estimated effects of the budget-neutral update to the adjustment to the Federal prospective payment rates for IRFs according to the percentage of low-income patients they treat, as discussed in section VI.B.5 of this final rule. Section 1886(j)(3)(A)(v) of the Act requires the Secretary to adjust the Federal prospective payment rates for IRFs under the IRF

PPS for such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In accordance with section 1886(j)(3)(A)(v) of the Act, we are changing the formula for the LIP adjustment, based on FY 2003 data with an adjustment to account for the absence of HealthSouth home office costs in that year (see the discussion in section IV of the preamble to this final rule), to raise the amount of 1 plus the DSH patient percentage to the power of 0.6229 instead of the power of 0.4838. Therefore, the formula to calculate the low-income patient or LIP adjustment will be as follows:

$$(1 + \text{DSH patient percentage}) \text{ raised to the power of } (.6229)$$

Where DSH patient percentage =

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

Because we are making this update to the LIP adjustment in a budget neutral manner, estimated payments will be redistributed among providers, according to their low-income percentages, but total estimated aggregate payments to facilities will not change. To do this, we applied a budget neutrality factor that lowered the standard payment amount in proportion to the amount of estimated payment increase that is attributable to the increased LIP adjustment

payments. This will result in no change to estimated aggregate payments, which is reflected in the projected zero impact shown in the first row of column 9 of Table 13. The remaining rows of the column show the estimated impacts on different categories of providers. On average, the estimated impacts of this change on any particular group of IRFs are small, with urban IRFs experiencing no change in estimated aggregate payments and rural IRFs experiencing a 0.1 percent decrease in estimated aggregate payments. The largest estimated impacts are a 1.1 percent estimated increase among IRFs with 10 percent or higher intern and resident to ADC ratios and a 0.8 percent estimated decrease among rural IRFs in the Pacific region.

11. All Changes (Column 12)

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

Column 12 reflects all estimated FY 2006 changes relative to FY 2005, shown in columns 4 through 11. The average estimated increase for all IRFs is approximately 3.4 percent. This estimated increase includes the effects of the 3.6 percent market basket update. It also reflects the

1.8 percentage point difference between the estimated outlier payments in FY 2005 (1.2 percent of total estimated payments) and the estimate of the percentage of outlier payments in FY 2006 (3 percent), as described in section VI.B.6 of this final rule. As a result, payments per discharge are estimated to be 1.8 percent lower in FY 2005 than they would have been had the 3 percent target outlier payment percentage been met, resulting in a 1.8 percent greater increase in total estimated FY 2006 payments than would otherwise have occurred.

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

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

12. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 15 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the changes presented in this final rule based on the data for 1,188 IRFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IRFs).

Table 15 - Accounting Statement: Classification of Estimated Expenditures, from FY 2005 to FY 2006 (in Millions)	
Category	TRANSFERS
Annualized Monetized Transfers	\$210
From Whom To Whom?	Federal Government To IRF Medicare Providers

13. Alternatives Considered

Because we have determined that this final rule will have a significant economic impact on IRFs, we will discuss the alternative changes to the IRF PPS that we considered. We reviewed the options considered in the proposed rule and took into consideration comments received during the public comment period as discussed in the preamble of this final rule.

The other option we considered before deciding to

update the CMGs with the fiscal year 2003 data was to maintain the same CMG structure but recalculate the relative weights for the current CMGs using the 2003 data. After carefully reviewing the results of RAND's regression analysis, which compared the predictive ability of the CMGs under 3 scenarios (not updating the CMGs or the relative weights, updating only the relative weights and not the CMGs, and updating both the relative weights and the CMGs), we believe (based on RAND's analysis and a careful review of the comments we received on the FY 2006 proposed rule (70 FR 30188)) that updating both the relative weights and the CMGs will allow the classification system to do a better job of reflecting changes in treatment patterns, technology, case mix, and other factors which may affect the relative use of resources. For these reasons, we believe these changes will improve the accuracy of payments in the IRF PPS.

We considered alternative options before deciding to implement an objective weighted motor score methodology for classifying patients into CMGs. The first of these options was to keep the non-weighted motor score methodology used previously. However, we considered weighted motor score methodologies because RAND's regression analysis indicated that the weighted methodologies would substantially improve the predictive ability of the system. We had not previously

proposed weighted motor score methodologies for the IRF PPS because most experts previously believed that the data were not complete and accurate enough before the IRF PPS (although they were the most complete and accurate data available at the time). However, the technical expert panel that reviewed RAND's analyses and advised RAND regarding the methodology generally indicated that the data are now sufficient to support a weight motor score.

RAND assessed different weighting methodologies for both the motor score index and the cognitive score index. They discovered that weighting the motor score index improved the predictive ability of the system, whereas weighting the cognitive score index did not. Furthermore, the cognitive score index has never had much of an effect (in some RICs, it has no effect) on the assignment of patients to CMGs because the motor score tends to be much stronger at predicting a patient's expected costs in an IRF than the cognitive score. For these reasons, we proposed a weighting methodology for the motor score index, but proposed to use the same cognitive score index used previously for the IRF classification system. We believe that it would be futile to expend resources on changing the cognitive score methodology at this time when it would not benefit the Medicare program.

We considered various weighted motor score methodologies, including one which would require computing 378 different weights (18 different weights for the motor and cognitive indices that could all differ across 21 RICs).

Rather than introduce this level of complexity to the system, RAND decided to explore simpler weighting methodologies that would still increase the predictive power of the system.

We also considered defining some simple combinations of the items that make up the motor score index and assigning weights to the groups of items instead of to the individual items. For example, we considered summing the three transfer items together to form a group with a weight of two, since they contributed about twice as much in the cost regression as the self-care items. We also considered assigning the self-care items a weight of one and the bladder and bowel items as a group a weight close to zero, since they contributed little to predicting cost in the regression analysis. We tried a number of variations and combinations of this, but RAND's TEP generally rejected these weighting schemes. They believed that introducing elements of subjectivity into the development of the weighting scheme may invite controversy, and that it is better to use an objective algorithm to derive the

appropriate weights. We agree that an objective weighting scheme is best because it is based on regression analysis of the amount that various components of the motor score index contribute to predicting patient costs, using the best available data we have. For this reason, we decided to adopt the weighting scheme that applies the average optimal weights.

We considered a reduction to the standard payment amount by an amount up to 5.8 percent because one of RAND's methodologies for determining the amount of real change in case mix and the amount of coding change that occurred between 1999 and 2002 suggested that coding change could possibly have been responsible for up to 5.8 percent of the observed increase in IRFs' case mix. Furthermore, a separate analysis by RAND found that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002 (some IRFs were still transitioning to PPS payments during 2002), PPS payments during 2002 would have been 17 percent higher than IRFs' costs. This suggests that we could potentially have implemented a reduction greater than 1.9 and up to 5.8 percent.

We decided to implement a 1.9 percent reduction to the standard payment amount, the lowest possible amount of change attributable to coding change for the following

reasons. First, the analyses described in this final rule are only the first of an ongoing series of studies to evaluate the existence and extent of payment increases due to coding changes. We will continue to review the need for any further reduction in the standard payment amount in subsequent years as part of our overall monitoring and evaluation of the IRF PPS. Second, we believe this approach, which is supported by RAND's analysis of the data, will adequately adjust for the increased payments to IRFs caused purely by coding changes, but will still provide the flexibility to account for the possibility that some of the observed changes in case mix may be attributed to other than coding changes. Furthermore, we chose the amount of the reduction in the standard payment amount in order to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criterion for IRF classification commonly known as the "75 percent rule." We considered the public comments we received on this issue and believe that 1.9 percent is the appropriate reduction to the standard payment amount at this time.

We considered no transition to implement the CBSA-based geographic classifications. However, based on further analysis (and in response to comments), we considered

various transition options. One option we considered was a 1-year budget neutral transition with a blended wage index (comprised of the FY 2006 MSA-based wage index and FY 2006 CBSA-based wage index) for IRFs that would experience a decrease in the wage index. We also considered floor and ceiling options as requested by commenters. However, the options did not reflect the policy goals to mitigate the overall impact of IRFs transitioning from the MSA-based wage index to the CBSA-based wage index while lessening the overall impact on the unadjusted base payment that would be equitable to all IRFs.

We also considered not adopting a hold harmless policy. However, based on additional review we determined that it was appropriate to implement a budget neutral 3 year hold harmless policy that would better reflect policy and maintain fiscal integrity of existing FY 2005 rural IRFs that will be redesignated as urban facilities under the CBSA-based designation.

We considered not proposing to add a teaching status adjustment to the IRF PPS because we had some concerns about proposing a teaching status adjustment for IRFs. The policy implications of implementing a teaching status adjustment on the basis of the results of RAND's recent analysis caused us to seek assurance that these results did not reflect an

aberration based on only a single year's data and that the teaching status adjustment could be implemented in such a way that it would be equitable to all IRFs.

However, the regression analysis conducted by RAND for CY 2002 and FY 2003 showed a statistically significant difference in costs between IRFs with teaching programs and those without teaching programs. After reviewing RAND's analysis and the comments we received on the teaching status adjustment we proposed in the FY 2006 proposed rule (70 FR 30188), which were generally favorable, we determined that a teaching status adjustment for IRFs is appropriate at this time. We will continue to analyze the need for this adjustment in future data.

We believe that the analysis conducted by RAND using calendar year 2002 and FY 2003 data (the best available data we have and the first available data since implementation of the IRF PPS) left us little option other than to update the rural and LIP adjustments and the outlier loss threshold amount. The regression analysis indicated that facility-level adjustments (the rural and the LIP adjustments) should be updated to better reflect the costs of care among different types of IRF facilities. Similarly the regression analysis indicated that the outlier threshold amount needed to be updated so that estimated outlier payments for FY 2006

would equal 3 percent of total estimated IRF payments for FY 2006.

14. Conclusion

Overall, estimated payments per discharge for IRFs in FY 2006 are projected to increase by 3.4 percent, as reflected in column 12 of Table 13. IRFs in urban areas will experience a 3.2 percent increase in estimated payments per discharge compared with FY 2005. IRFs in rural areas, meanwhile, will experience a 5.7 percent estimated increase.

Rehabilitation units in urban areas will experience a 5.3 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in urban areas will experience no change in estimated payments per discharge. Rehabilitation units in rural areas will experience a 5.5 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in rural areas will experience a 6.5 percent increase in estimated payments per discharge.

Overall, the largest estimated payment increase will be 27.4 percent among teaching IRFs with an intern and resident to ADC ratio greater than 19 percent and 14.3 percent among teaching IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent. This is largely due to the teaching status

adjustment. Other than for teaching IRFs, the largest estimated payment increase will be 10.3 percent among rural IRFs located in the Middle Atlantic region. This is due largely to the change in the CBSA-based designation from urban to rural, whereby the number of cases in the rural Middle Atlantic Region that will receive the new rural adjustment of 21.3 percent is projected to increase. The only overall decrease in estimated payments will occur among urban IRFs located in the Mountain census region, a decrease in estimated payments of 0.2 percent. This is due largely to the change in the CBSA-based designation from rural to urban. For non-profit IRFs, we found that rural non-profit facilities will receive the largest estimated payment increase of 6.7 percent. Conversely, for-profit urban facilities are projected to experience no change in payments for FY 2006.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

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

For the reasons set forth in the preamble, CMS amends 42 CFR chapter IV part 412 as set forth below:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

2. Section 412.25 is amended by revising paragraph (a), introductory text, 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 as specified in §412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in §412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in §412.1(a)(3), a psychiatric or rehabilitation unit must meet the following requirements.

* * *
* * *

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

§412.602 Definitions.

* * * * *

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

* * * * *

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

§412.622 [Amended]

4. Section 412.622 is amended by—

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

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

5. Section 412.624 is amended by--

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

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

C. Revising paragraphs (e)(4) and (e)(5).

D. Adding new paragraphs (e)(6) and (e)(7).

E. In paragraph (f)(2)(v), removing the cross references to "paragraphs (e)(1), (e)(2), and (e)(3) of this section" and adding in their place "paragraphs (e)(2), (e)(3), (e)(4), and (e)(7) of this section".

The revisions and additions read as follows:

§412.624 Methodology for calculating the Federal prospective payment rates.

* * * *
(d) * * *

(4) Payment adjustment for Federal fiscal year 2006 and applicable Federal fiscal years. CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (e)(3), (e)(4) and (e)(7), of this section, and to any revision specified in §412.620(c) by a factor as specified by the Secretary.

(e) * * *

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

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

payments made under this section will also be subject to adjustments at \$412.84(m).

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

(7) Adjustments for certain facilities geographically redesignated in FY 2006.

(i) General. For a facility defined as an urban facility under §412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under §412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY 2006 and it no longer qualified for the rural adjustment under §412.624(e)(3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's

payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) Exception. For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e) (7) (i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under §412.624(e) (3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e) (7) (i) (A) and (e) (7) (i) (B) of this section as determined by us.

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

Dated: _____

Mark B. McClellan,
Administrator,
Centers for Medicare & Medicaid
Services.

Approved: _____

Michael O. Leavitt,
Secretary.

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

Table 1 - FY 2006 IRF PPS Transition Wage Index Table
 (For discharges occurring on or after October 1, 2005 and on or before September 30, 2006)

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
01000	Autauga County, Alabama	5240	Urban	0.8300	0.8300	33860	Urban	0.8300
01010	Baldwin County, Alabama	5160	Urban	0.7932	0.7628	99901	Rural	0.7780
01020	Barbour County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01030	Bibb County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
01040	Blount County, Alabama	1000	Urban	0.9198	0.9157	13820	Urban	0.9178
01050	Bullock County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01060	Butler County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01070	Calhoun County, Alabama	0450	Urban	0.7881	0.7881	11500	Urban	0.7881
01080	Chambers County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01090	Cherokee County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01100	Chilton County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
01110	Choctaw County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01120	Clarke County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01130	Clay County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01140	Cleburne County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01150	Coffee County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01160	Colbert County, Alabama	2650	Urban	0.7883	0.7883	22520	Urban	0.7883
01170	Conecuh County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01180	Coosa County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01190	Covington County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01200	Crenshaw County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01210	Cullman County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01220	Dale County, Alabama	2180	Urban	0.7596	0.7628	99901	Rural	0.7612
01230	Dallas County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01240	De Kalb County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01250	Elmore County, Alabama	5240	Urban	0.8300	0.8300	33860	Urban	0.8300
01260	Escambia County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01270	Etowah County, Alabama	2880	Urban	0.8049	0.8049	23460	Urban	0.8049
01280	Fayette County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01290	Franklin County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01300	Geneva County, Alabama	01	Rural	0.7637	0.7537	20020	Urban	0.7587
01310	Greene County, Alabama	01	Rural	0.7637	0.8336	46220	Urban	0.7987
01320	Hale County, Alabama	01	Rural	0.7637	0.8336	46220	Urban	0.7987
01330	Henry County, Alabama	01	Rural	0.7637	0.7537	20020	Urban	0.7587
01340	Houston County, Alabama	2180	Urban	0.7596	0.7537	20020	Urban	0.7567
01350	Jackson County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01360	Jefferson County, Alabama	1000	Urban	0.9198	0.9157	13820	Urban	0.9178
01370	Lamar County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01380	Lauderdale County, Alabama	2650	Urban	0.7883	0.7883	22520	Urban	0.7883
01390	Lawrence County, Alabama	2030	Urban	0.8894	0.8894	19460	Urban	0.8894

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
01400	Lee County, Alabama	0580	Urban	0.8215	0.8215	12220	Urban	0.8215
01410	Limestone County, Alabama	3440	Urban	0.8851	0.8851	26620	Urban	0.8851
01420	Lowndes County, Alabama	01	Rural	0.7637	0.8300	33860	Urban	0.7969
01430	Macon County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01440	Madison County, Alabama	3440	Urban	0.8851	0.8851	26620	Urban	0.8851
01450	Marengo County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01460	Marion County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01470	Marshall County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01480	Mobile County, Alabama	5160	Urban	0.7932	0.7995	33660	Urban	0.7964
01490	Monroe County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01500	Montgomery County, Alabama	5240	Urban	0.8300	0.8300	33860	Urban	0.8300
01510	Morgan County, Alabama	2030	Urban	0.8894	0.8894	19460	Urban	0.8894
01520	Perry County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01530	Pickens County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01540	Pike County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01550	Randolph County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01560	Russell County, Alabama	1800	Urban	0.8690	0.8690	17980	Urban	0.8690
01570	St Clair County, Alabama	1000	Urban	0.9198	0.9157	13820	Urban	0.9178
01580	Shelby County, Alabama	1000	Urban	0.9198	0.9157	13820	Urban	0.9178
01590	Sumter County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01600	Talladega County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01610	Tallapoosa County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01620	Tuscaloosa County, Alabama	8600	Urban	0.8440	0.8336	46220	Urban	0.8388
01630	Walker County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
01640	Washington County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01650	Wilcox County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
01660	Winston County, Alabama	01	Rural	0.7637	0.7628	99901	Rural	0.7633
02013	Aleutians County East, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02016	Aleutians County West, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02020	Anchorage County, Alaska	0380	Urban	1.2109	1.2165	11260	Urban	1.2137
02030	Angeon County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02040	Barrow-North Slope County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02050	Bethel County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02060	Bristol Bay Borough County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02068	Denali County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02070	Bristol Bay County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02080	Cordova-Mc Carthy County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02090	Fairbanks County, Alaska	02	Rural	1.1637	1.1146	21820	Urban	1.1392
02100	Haines County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02110	Juneau County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02120	Kenai-Cook Inlet County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02122	Kenai Peninsula Borough, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02130	Ketchikan County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692

SSA State/County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
02140	Kobuk County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02150	Kodiak County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02160	Kuskokwin County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02164	Lake and Peninsula Borough, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02170	Matanuska County, Alaska	02	Rural	1.1637	1.2165	11260	Urban	1.1901
02180	Nome County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02185	North Slope Borough, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02188	Northwest Arctic Borough, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02190	Outer Ketchikan County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02200	Prince Of Wales County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02201	Prince of Wales-Outer Ketchikan Census Area, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02210	Seward County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02220	Sitka County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02230	Skagway-Yakutat County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02231	Skagway-Yakutat-Angoon Census Area, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02232	Skagway-Hoonah-Angoon Census Area, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02240	Southeast Fairbanks County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02250	Upper Yukon County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02260	Valdez-Chitna-Whitier County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02261	Valdex-Cordove Census Area, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02270	Wade Hampton County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02280	Wrangell-Petersburg County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02282	Yakutat Borough, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
02290	Yukon-Koyukuk County, Alaska	02	Rural	1.1637	1.1746	99902	Rural	1.1692
03000	Apache County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03010	Cochise County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03020	Coconino County, Arizona	2620	Urban	1.0611	1.0787	22380	Urban	1.0699
03030	Gila County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03040	Graham County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03050	Greenlee County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03055	La Paz County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03060	Maricopa County, Arizona	6200	Urban	0.9982	0.9982	38060	Urban	0.9982
03070	Mohave County, Arizona	4120	Urban	1.1121	0.8936	99903	Rural	1.0029
03080	Navajo County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03090	Pima County, Arizona	8520	Urban	0.8926	0.8926	46060	Urban	0.8926
03100	Pinal County, Arizona	6200	Urban	0.9982	0.9982	38060	Urban	0.9982
03110	Santa Cruz County, Arizona	03	Rural	0.9140	0.8936	99903	Rural	0.9038
03120	Yavapai County, Arizona	03	Rural	0.9140	0.9892	39140	Urban	0.9516
03130	Yuma County, Arizona	9360	Urban	0.8871	0.8871	49740	Urban	0.8871
04000	Arkansas County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04010	Ashley County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04020	Baxter County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
04030	Benton County, Arkansas	2580	Urban	0.8636	0.8636	22220	Urban	0.8636
04040	Boone County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04050	Bradley County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04060	Calhoun County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04070	Carroll County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04080	Chicot County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04090	Clark County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04100	Clay County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04110	Cleburne County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04120	Cleveland County, Arkansas	04	Rural	0.7703	0.8673	38220	Urban	0.8188
04130	Columbia County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04140	Conway County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04150	Craighead County, Arkansas	3700	Urban	0.8144	0.8144	27860	Urban	0.8144
04160	Crawford County, Arkansas	2720	Urban	0.8303	0.8283	22900	Urban	0.8293
04170	Crittenden County, Arkansas	4920	Urban	0.9234	0.9217	32820	Urban	0.9226
04180	Cross County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04190	Dallas County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04200	Desha County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04210	Drew County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04220	Faulkner County, Arkansas	4400	Urban	0.8826	0.8826	30780	Urban	0.8826
04230	Franklin County, Arkansas	04	Rural	0.7703	0.8283	22900	Urban	0.7993
04240	Fulton County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04250	Garland County, Arkansas	04	Rural	0.7703	0.9249	26300	Urban	0.8476
04260	Grant County, Arkansas	04	Rural	0.7703	0.8826	30780	Urban	0.8265
04270	Greene County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04280	Hempstead County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04290	Hot Spring County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04300	Howard County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04310	Independence County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04320	Izard County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04330	Jackson County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04340	Jefferson County, Arkansas	6240	Urban	0.8673	0.8673	38220	Urban	0.8673
04350	Johnson County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04360	Lafayette County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04370	Lawrence County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04380	Lee County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04390	Lincoln County, Arkansas	04	Rural	0.7703	0.8673	38220	Urban	0.8188
04400	Little River County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04410	Logan County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04420	Lonoke County, Arkansas	4400	Urban	0.8826	0.8826	30780	Urban	0.8826
04430	Madison County, Arkansas	04	Rural	0.7703	0.8636	22220	Urban	0.8170
04440	Marion County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04450	Miller County, Arkansas	8360	Urban	0.8413	0.8413	45500	Urban	0.8413

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
04460	Mississippi County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04470	Monroe County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04480	Montgomery County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04490	Nevada County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04500	Newton County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04510	Ouachita County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04520	Perry County, Arkansas	04	Rural	0.7703	0.8826	30780	Urban	0.8265
04530	Phillips County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04540	Pike County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04550	Poinsett County, Arkansas	04	Rural	0.7703	0.8144	27860	Urban	0.7924
04560	Polk County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04570	Pope County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04580	Prairie County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04590	Pulaski County, Arkansas	4400	Urban	0.8826	0.8826	30780	Urban	0.8826
04600	Randolph County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04610	St Francis County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04620	Saline County, Arkansas	4400	Urban	0.8826	0.8826	30780	Urban	0.8826
04630	Scott County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04640	Searcy County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04650	Sebastian County, Arkansas	2720	Urban	0.8303	0.8283	22900	Urban	0.8293
04660	Sevier County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04670	Sharp County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04680	Stone County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04690	Union County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04700	Van Buren County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04710	Washington County, Arkansas	2580	Urban	0.8636	0.8636	22220	Urban	0.8636
04720	White County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04730	Woodruff County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
04740	Yell County, Arkansas	04	Rural	0.7703	0.7406	99904	Rural	0.7555
05000	Alameda County, California	5775	Urban	1.5220	1.5220	36084	Urban	1.5220
05010	Alpine County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05020	Amador County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05030	Butte County, California	1620	Urban	1.0542	1.0542	17020	Urban	1.0542
05040	Calaveras County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05050	Colusa County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05060	Contra Costa County, California	5775	Urban	1.5220	1.5220	36084	Urban	1.5220
05070	Del Norte County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05080	Eldorado County, California	6920	Urban	1.1848	1.1700	40900	Urban	1.1774
05090	Fresno County, California	2840	Urban	1.0407	1.0536	23420	Urban	1.0472
05100	Glenn County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05110	Humboldt County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05120	Imperial County, California	05	Rural	1.0297	0.8856	20940	Urban	0.9577
05130	Inyo County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411

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05140	Kern County, California	0680	Urban	1.0036	1.0036	12540	Urban	1.0036
05150	Kings County, California	05	Rural	1.0297	0.9296	25260	Urban	0.9797
05160	Lake County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05170	Lassen County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05200	Los Angeles County, California	4480	Urban	1.1732	1.1732	31084	Urban	1.1732
05210	Los Angeles County, California	4480	Urban	1.1732	1.1732	31084	Urban	1.1732
05300	Madera County, California	2840	Urban	1.0407	0.8521	31460	Urban	0.9464
05310	Marin County, California	7360	Urban	1.4712	1.4712	41884	Urban	1.4712
05320	Mariposa County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05330	Mendocino County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05340	Merced County, California	4940	Urban	1.0575	1.0575	32900	Urban	1.0575
05350	Modoc County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05360	Mono County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05370	Monterey County, California	7120	Urban	1.3823	1.3823	41500	Urban	1.3823
05380	Napa County, California	8720	Urban	1.3517	1.2531	34900	Urban	1.3024
05390	Nevada County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05400	Orange County, California	5945	Urban	1.1611	1.1611	42044	Urban	1.1611
05410	Placer County, California	6920	Urban	1.1848	1.1700	40900	Urban	1.1774
05420	Plumas County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05430	Riverside County, California	6780	Urban	1.0970	1.0970	40140	Urban	1.0970
05440	Sacramento County, California	6920	Urban	1.1848	1.1700	40900	Urban	1.1774
05450	San Benito County, California	05	Rural	1.0297	1.4722	41940	Urban	1.2510
05460	San Bernardino County, California	6780	Urban	1.0970	1.0970	40140	Urban	1.0970
05470	San Diego County, California	7320	Urban	1.1267	1.1267	41740	Urban	1.1267
05480	San Francisco County, California	7360	Urban	1.4712	1.4712	41884	Urban	1.4712
05490	San Joaquin County, California	8120	Urban	1.0564	1.0564	44700	Urban	1.0564
05500	San Luis Obispo County, California	7460	Urban	1.1118	1.1118	42020	Urban	1.1118
05510	San Mateo County, California	7360	Urban	1.4712	1.4712	41884	Urban	1.4712
05520	Santa Barbara County, California	7480	Urban	1.0771	1.0771	42060	Urban	1.0771
05530	Santa Clara County, California	7400	Urban	1.4744	1.4722	41940	Urban	1.4733
05540	Santa Cruz County, California	7485	Urban	1.4779	1.4779	42100	Urban	1.4779
05550	Shasta County, California	6690	Urban	1.1835	1.1835	39820	Urban	1.1835
05560	Sierra County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05570	Siskiyou County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05580	Solano County, California	8720	Urban	1.3517	1.4279	46700	Urban	1.3898
05590	Sonoma County, California	7500	Urban	1.2961	1.2961	42220	Urban	1.2961
05600	Stanislaus County, California	5170	Urban	1.1966	1.1966	33700	Urban	1.1966
05610	Sutter County, California	9340	Urban	1.0363	1.0363	49700	Urban	1.0363
05620	Tehama County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05630	Trinity County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05640	Tulare County, California	8780	Urban	0.9975	0.9975	47300	Urban	0.9975
05650	Tuolumne County, California	05	Rural	1.0297	1.0524	99905	Rural	1.0411
05660	Ventura County, California	8735	Urban	1.1105	1.1105	37100	Urban	1.1105

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05670	Yolo County, California	9270	Urban	0.9378	1.1700	40900	Urban	1.0539
05680	Yuba County, California	9340	Urban	1.0363	1.0363	49700	Urban	1.0363
06000	Adams County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
06010	Alamosa County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06020	Arapahoe County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
06030	Archuleta County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06040	Baca County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06050	Bent County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06060	Boulder County, Colorado	1125	Urban	1.0046	1.0046	14500	Urban	1.0046
06070	Chaffee County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06080	Cheyenne County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06090	Clear Creek County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06100	Conejos County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06110	Costilla County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06120	Crowley County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06130	Custer County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06140	Delta County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06150	Denver County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
06160	Dolores County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06170	Douglas County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
06180	Eagle County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06190	Elbert County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06200	El Paso County, Colorado	1720	Urban	0.9792	0.9792	17820	Urban	0.9792
06210	Fremont County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06220	Garfield County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06230	Gilpin County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06240	Grand County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06250	Gunnison County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06260	Hinsdale County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06270	Huerfano County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06280	Jackson County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06290	Jefferson County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
06300	Kiowa County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06310	Kit Carson County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06320	Lake County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06330	La Plata County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06340	Larimer County, Colorado	2670	Urban	1.0218	1.0218	22660	Urban	1.0218
06350	Las Animas County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06360	Lincoln County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06370	Logan County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06380	Mesa County, Colorado	2995	Urban	0.9900	0.9900	24300	Urban	0.9900
06390	Mineral County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06400	Moffat County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368

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06410	Montezuma County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06420	Montrose County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06430	Morgan County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06440	Otero County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06450	Ouray County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06460	Park County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06470	Phillips County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06480	Pitkin County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06490	Prowers County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06500	Pueblo County, Colorado	6560	Urban	0.8752	0.8752	39380	Urban	0.8752
06510	Rio Blanco County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06520	Rio Grande County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06530	Routt County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06540	Saguache County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06550	San Juan County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06560	San Miguel County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06570	Sedgwick County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06580	Summit County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06590	Teller County, Colorado	06	Rural	0.9368	0.9792	17820	Urban	0.9580
06600	Washington County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06610	Weld County, Colorado	3060	Urban	0.9444	0.9444	24540	Urban	0.9444
06620	Yuma County, Colorado	06	Rural	0.9368	0.9368	99906	Rural	0.9368
06630	Broomfield County, Colorado	2080	Urban	1.0904	1.0904	19740	Urban	1.0904
07000	Fairfield County, Connecticut	5483	Urban	1.2254	1.2835	14860	Urban	1.2545
07010	Hartford County, Connecticut	3283	Urban	1.1054	1.1054	25540	Urban	1.1054
07020	Litchfield County, Connecticut	3283	Urban	1.1054	1.1054	25540	Urban	1.1054
07030	Middlesex County, Connecticut	3283	Urban	1.1054	1.1054	25540	Urban	1.1054
07040	New Haven County, Connecticut	5483	Urban	1.2254	1.1807	35300	Urban	1.2031
07050	New London County, Connecticut	5523	Urban	1.1596	1.1596	35980	Urban	1.1596
07060	Tolland County, Connecticut	3283	Urban	1.1054	1.1054	25540	Urban	1.1054
07070	Windham County, Connecticut	07	Rural	1.1917	1.1917	99907	Rural	1.1917
08000	Kent County, Delaware	2190	Urban	0.9825	0.9825	20100	Urban	0.9825
08010	New Castle County, Delaware	9160	Urban	1.1121	1.1049	48864	Urban	1.1085
08020	Sussex County, Delaware	08	Rural	0.9503	0.9503	99908	Rural	0.9503
09000	Washington Dc County, Dist Of Col	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
10000	Alachua County, Florida	2900	Urban	0.9459	0.9459	23540	Urban	0.9459
10010	Baker County, Florida	10	Rural	0.8721	0.9537	27260	Urban	0.9129
10020	Bay County, Florida	6015	Urban	0.8124	0.8124	37460	Urban	0.8124
10030	Bradford County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10040	Brevard County, Florida	4900	Urban	0.9633	0.9633	37340	Urban	0.9633
10050	Broward County, Florida	2680	Urban	1.0165	1.0165	22744	Urban	1.0165
10060	Calhoun County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10070	Charlotte County, Florida	6580	Urban	0.9441	0.9441	39460	Urban	0.9441

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10080	Citrus County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10090	Clay County, Florida	3600	Urban	0.9548	0.9537	27260	Urban	0.9543
10100	Collier County, Florida	5345	Urban	1.0558	1.0558	34940	Urban	1.0558
10110	Columbia County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10120	Dade County, Florida	5000	Urban	0.9870	0.9870	33124	Urban	0.9870
10130	De Soto County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10140	Dixie County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10150	Duval County, Florida	3600	Urban	0.9548	0.9537	27260	Urban	0.9543
10160	Escambia County, Florida	6080	Urban	0.8306	0.8306	37860	Urban	0.8306
10170	Flagler County, Florida	2020	Urban	0.8900	0.8574	99910	Rural	0.8737
10180	Franklin County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10190	Gadsden County, Florida	8240	Urban	0.8655	0.8655	45220	Urban	0.8655
10200	Gilchrist County, Florida	10	Rural	0.8721	0.9459	23540	Urban	0.9090
10210	Glades County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10220	Gulf County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10230	Hamilton County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10240	Hardee County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10250	Hendry County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10260	Hernando County, Florida	8280	Urban	0.9024	0.9024	45300	Urban	0.9024
10270	Highlands County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10280	Hillsborough County, Florida	8280	Urban	0.9024	0.9024	45300	Urban	0.9024
10290	Holmes County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10300	Indian River County, Florida	10	Rural	0.8721	0.9477	46940	Urban	0.9099
10310	Jackson County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10320	Jefferson County, Florida	10	Rural	0.8721	0.8655	45220	Urban	0.8688
10330	Lafayette County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10340	Lake County, Florida	5960	Urban	0.9742	0.9742	36740	Urban	0.9742
10350	Lee County, Florida	2700	Urban	0.9371	0.9371	15980	Urban	0.9371
10360	Leon County, Florida	8240	Urban	0.8655	0.8655	45220	Urban	0.8655
10370	Levy County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10380	Liberty County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10390	Madison County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10400	Manatee County, Florida	7510	Urban	0.9629	0.9629	42260	Urban	0.9629
10410	Marion County, Florida	5790	Urban	0.9153	0.9153	36100	Urban	0.9153
10420	Martin County, Florida	2710	Urban	1.0046	1.0046	38940	Urban	1.0046
10430	Monroe County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10440	Nassau County, Florida	3600	Urban	0.9548	0.9537	27260	Urban	0.9543
10450	Okaloosa County, Florida	2750	Urban	0.8786	0.8786	23020	Urban	0.8786
10460	Okeechobee County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10470	Orange County, Florida	5960	Urban	0.9742	0.9742	36740	Urban	0.9742
10480	Osceola County, Florida	5960	Urban	0.9742	0.9742	36740	Urban	0.9742
10490	Palm Beach County, Florida	8960	Urban	1.0362	1.0362	48424	Urban	1.0362
10500	Pasco County, Florida	8280	Urban	0.9024	0.9024	45300	Urban	0.9024

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10510	Pinellas County, Florida	8280	Urban	0.9024	0.9024	45300	Urban	0.9024
10520	Polk County, Florida	3980	Urban	0.8930	0.8930	29460	Urban	0.8930
10530	Putnam County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10540	Johns County, Florida	3600	Urban	0.9548	0.9537	27260	Urban	0.9543
10550	St Lucie County, Florida	2710	Urban	1.0046	1.0046	38940	Urban	1.0046
10560	Santa Rosa County, Florida	6080	Urban	0.8306	0.8306	37860	Urban	0.8306
10570	Sarasota County, Florida	7510	Urban	0.9629	0.9629	42260	Urban	0.9629
10580	Seminole County, Florida	5960	Urban	0.9742	0.9742	36740	Urban	0.9742
10590	Sumter County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10600	Suwannee County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10610	Taylor County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10620	Union County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10630	Volusia County, Florida	2020	Urban	0.8900	0.8898	19660	Urban	0.8899
10640	Wakulla County, Florida	10	Rural	0.8721	0.8655	45220	Urban	0.8688
10650	Walton County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
10660	Washington County, Florida	10	Rural	0.8721	0.8574	99910	Rural	0.8648
11000	Appling County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11010	Atkinson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11011	Bacon County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11020	Baker County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
11030	Baldwin County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11040	Banks County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11050	Barrow County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11060	Bartow County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11070	Ben Hill County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11080	Berrien County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11090	Bibb County, Georgia	4680	Urban	0.9596	0.9887	31420	Urban	0.9742
11100	Bleckley County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11110	Brantley County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11120	Brooks County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11130	Bryan County, Georgia	7520	Urban	0.9460	0.9460	42340	Urban	0.9460
11140	Bulloch County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11150	Burke County, Georgia	11	Rural	0.8247	0.9154	12260	Urban	0.8701
11160	Butts County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11161	Calhoun County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11170	Camden County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11180	Candler County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11190	Carroll County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11200	Catoosa County, Georgia	1560	Urban	0.9207	0.9207	16860	Urban	0.9207
11210	Charlton County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11220	Chatham County, Georgia	7520	Urban	0.9460	0.9460	42340	Urban	0.9460
11230	Chattahoochee County, Georgia	1800	Urban	0.8690	0.8690	17980	Urban	0.8690
11240	Chattooga County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990

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11250	Cherokee County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11260	Clarke County, Georgia	0500	Urban	1.0202	1.0202	12020	Urban	1.0202
11270	Clay County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11280	Clayton County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11281	Clinch County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11290	Cobb County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11291	Coffee County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11300	Colquitt County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11310	Columbia County, Georgia	0600	Urban	0.9208	0.9154	12260	Urban	0.9181
11311	Cook County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11320	Coweta County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11330	Crawford County, Georgia	11	Rural	0.8247	0.9887	31420	Urban	0.9067
11340	Crisp County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11341	Dade County, Georgia	1560	Urban	0.9207	0.9207	16860	Urban	0.9207
11350	Dawson County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11360	Decatur County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11370	De Kalb County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11380	Dodge County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11381	Dooly County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11390	Dougherty County, Georgia	0120	Urban	1.1266	1.1266	10500	Urban	1.1266
11400	Douglas County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11410	Early County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11420	Echols County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11421	Effingham County, Georgia	7520	Urban	0.9460	0.9460	42340	Urban	0.9460
11430	Elbert County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11440	Emanuel County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11441	Evans County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11450	Fannin County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11451	Fayette County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11460	Floyd County, Georgia	11	Rural	0.8247	0.8878	40660	Urban	0.8563
11461	Forsyth County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11462	Franklin County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11470	Fulton County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11471	Gilmer County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11480	GlascocK County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11490	Glynn County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11500	Gordon County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11510	Grady County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11520	Greene County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11530	Gwinnett County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11540	Habersham County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11550	Hall County, Georgia	11	Rural	0.8247	0.9557	23580	Urban	0.8902
11560	Hancock County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990

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11570	Haralson County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11580	Harris County, Georgia	1800	Urban	0.8690	0.8690	17980	Urban	0.8690
11581	Hart County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11590	Heard County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11591	Henry County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11600	Houston County, Georgia	4680	Urban	0.9596	0.8489	47580	Urban	0.9043
11601	Irwin County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11610	Jackson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11611	Jasper County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11612	Jeff Davis County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11620	Jefferson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11630	Jenkins County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11640	Johnson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11650	Jones County, Georgia	4680	Urban	0.9596	0.9887	31420	Urban	0.9742
11651	Lamar County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11652	Lanier County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11660	Laurens County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11670	Lee County, Georgia	0120	Urban	1.1266	1.1266	10500	Urban	1.1266
11680	Liberty County, Georgia	11	Rural	0.8247	0.7715	25980	Urban	0.7981
11690	Lincoln County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11691	Long County, Georgia	11	Rural	0.8247	0.7715	25980	Urban	0.7981
11700	Lowndes County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11701	Lumpkin County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11702	Mc Duffie County, Georgia	0600	Urban	0.9208	0.9154	12260	Urban	0.9181
11703	Mc Intosh County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11710	Macon County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11720	Madison County, Georgia	0500	Urban	1.0202	1.0202	12020	Urban	1.0202
11730	Marion County, Georgia	11	Rural	0.8247	0.8690	17980	Urban	0.8469
11740	Meriwether County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11741	Miller County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11750	Mitchell County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11760	Monroe County, Georgia	11	Rural	0.8247	0.9887	31420	Urban	0.9067
11770	Montgomery County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11771	Morgan County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11772	Murray County, Georgia	11	Rural	0.8247	0.9558	19140	Urban	0.8903
11780	Muscogee County, Georgia	1800	Urban	0.8690	0.8690	17980	Urban	0.8690
11790	Newton County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11800	Oconee County, Georgia	0500	Urban	1.0202	1.0202	12020	Urban	1.0202
11801	Oglethorpe County, Georgia	11	Rural	0.8247	1.0202	12020	Urban	0.9225
11810	Paulding County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11811	Peach County, Georgia	4680	Urban	0.9596	0.7733	99911	Rural	0.8665
11812	Pickens County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11820	Pierce County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990

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11821	Pike County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11830	Polk County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11831	Pulaski County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11832	Putnam County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11833	Quitman County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11834	Rabun County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11835	Randolph County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11840	Richmond County, Georgia	0600	Urban	0.9208	0.9154	12260	Urban	0.9181
11841	Rockdale County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11842	Schley County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11850	Screven County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11851	Seminole County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11860	Spalding County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11861	Stephens County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11862	Stewart County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11870	Sumter County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11880	Talbot County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11881	Taliaferro County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11882	Tattnall County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11883	Taylor County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11884	Telfair County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11885	Terrell County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
11890	Thomas County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11900	Tift County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11901	Toombs County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11902	Towns County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11903	Treutlen County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11910	Troup County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11911	Turner County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11912	Twiggs County, Georgia	4680	Urban	0.9596	0.9887	31420	Urban	0.9742
11913	Union County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11920	Upson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11921	Walker County, Georgia	1560	Urban	0.9207	0.9207	16860	Urban	0.9207
11930	Walton County, Georgia	0520	Urban	0.9971	0.9971	12060	Urban	0.9971
11940	Ware County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11941	Warren County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11950	Washington County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11960	Wayne County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11961	Webster County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11962	Wheeler County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11963	White County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11970	Whitfield County, Georgia	11	Rural	0.8247	0.9558	19140	Urban	0.8903
11971	Wilcox County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990

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11972	Wilkes County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11973	Wilkinson County, Georgia	11	Rural	0.8247	0.7733	99911	Rural	0.7990
11980	Worth County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
12005	Kalawao County, Hawaii	12	Rural	1.0522	1.0522	99912	Rural	1.0522
12010	Hawaii County, Hawaii	12	Rural	1.0522	1.0522	99912	Rural	1.0522
12020	Honolulu County, Hawaii	3320	Urban	1.1013	1.1013	26180	Urban	1.1013
12040	Kauai County, Hawaii	12	Rural	1.0522	1.0522	99912	Rural	1.0522
12050	Maui County, Hawaii	12	Rural	1.0522	1.0522	99912	Rural	1.0522
13000	Ada County, Idaho	1080	Urban	0.9352	0.9352	14260	Urban	0.9352
13010	Adams County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13020	Bannock County, Idaho	6340	Urban	0.9601	0.9601	38540	Urban	0.9601
13030	Bear Lake County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13040	Benewah County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13050	Bingham County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13060	Blaine County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13070	Boise County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13080	Bonner County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13090	Bonneville County, Idaho	13	Rural	0.8826	0.9059	26820	Urban	0.8943
13100	Boundary County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13110	Butte County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13120	Camas County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13130	Canyon County, Idaho	1080	Urban	0.9352	0.9352	14260	Urban	0.9352
13140	Caribou County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13150	Cassia County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13160	Clark County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13170	Clearwater County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13180	Custer County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13190	Elmore County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13200	Franklin County, Idaho	13	Rural	0.8826	0.9094	30860	Urban	0.8960
13210	Fremont County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13220	Gem County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13230	Gooding County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13240	Idaho County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13250	Jefferson County, Idaho	13	Rural	0.8826	0.9059	26820	Urban	0.8943
13260	Jerome County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13270	Kootenai County, Idaho	13	Rural	0.8826	0.9339	17660	Urban	0.9083
13280	Latah County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13290	Lemhi County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13300	Lewis County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13310	Lincoln County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13320	Madison County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13330	Minidoka County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13340	Nez Perce County, Idaho	13	Rural	0.8826	0.9314	30300	Urban	0.9070

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
13350	Oneida County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13360	Owyhee County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13370	Payette County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13380	Power County, Idaho	13	Rural	0.8826	0.9601	38540	Urban	0.9214
13390	Shoshone County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13400	Teton County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13410	Twin Falls County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13420	Valley County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
13430	Washington County, Idaho	13	Rural	0.8826	0.8227	99913	Rural	0.8527
14000	Adams County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14010	Alexander County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14020	Bond County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14030	Boone County, Illinois	6880	Urban	0.9626	0.9626	40420	Urban	0.9626
14040	Brown County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14050	Bureau County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14060	Calhoun County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14070	Carroll County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14080	Cass County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14090	Champaign County, Illinois	1400	Urban	0.9527	0.9527	16580	Urban	0.9527
14100	Christian County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14110	Clark County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14120	Clay County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14130	Clinton County, Illinois	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
14140	Coles County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14141	Cook County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14150	Crawford County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14160	Cumberland County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14170	De Kalb County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14180	De Witt County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14190	Douglas County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14250	Du Page County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14310	Edgar County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14320	Edwards County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14330	Effingham County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14340	Fayette County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14350	Ford County, Illinois	14	Rural	0.8340	0.9527	16580	Urban	0.8934
14360	Franklin County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14370	Fulton County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14380	Gallatin County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14390	Greene County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14400	Grundy County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14410	Hamilton County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14420	Hancock County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340

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14421	Hardin County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14440	Henderson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14450	Henry County, Illinois	1960	Urban	0.8773	0.8773	19340	Urban	0.8773
14460	Iroquois County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14470	Jackson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14480	Jasper County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14490	Jefferson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14500	Jersey County, Illinois	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
14510	Jo Daviess County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14520	Johnson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14530	Kane County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14540	Kankakee County, Illinois	3740	Urban	1.0603	1.0603	28100	Urban	1.0603
14550	Kendall County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14560	Knox County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14570	Lake County, Illinois	1600	Urban	1.0851	1.0342	29404	Urban	1.0597
14580	La Salle County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14590	Lawrence County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14600	Lee County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14610	Livingston County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14620	Logan County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14630	Mc Donough County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14640	Mc Henry County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14650	Mclean County, Illinois	1040	Urban	0.9111	0.9111	14060	Urban	0.9111
14660	Macon County, Illinois	2040	Urban	0.8122	0.8122	19500	Urban	0.8122
14670	Macoupin County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14680	Madison County, Illinois	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
14690	Marion County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14700	Marshall County, Illinois	14	Rural	0.8340	0.8886	37900	Urban	0.8613
14710	Mason County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14720	Massac County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14730	Menard County, Illinois	7880	Urban	0.8738	0.8738	44100	Urban	0.8738
14740	Mercer County, Illinois	14	Rural	0.8340	0.8773	19340	Urban	0.8557
14750	Monroe County, Illinois	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
14760	Montgomery County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14770	Morgan County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14780	Moultrie County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14790	Ogle County, Illinois	6880	Urban	0.9626	0.8339	99914	Rural	0.8983
14800	Peoria County, Illinois	6120	Urban	0.8886	0.8886	37900	Urban	0.8886
14810	Perry County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14820	Piatt County, Illinois	14	Rural	0.8340	0.9527	16580	Urban	0.8934
14830	Pike County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14831	Pope County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14850	Pulaski County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340

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14860	Putnam County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14870	Randolph County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14880	Richland County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14890	Rock Island County, Illinois	1960	Urban	0.8773	0.8773	19340	Urban	0.8773
14900	St Clair County, Illinois	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
14910	Saline County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14920	Sangamon County, Illinois	7880	Urban	0.8738	0.8738	44100	Urban	0.8738
14921	Schuyler County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14940	Scott County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14950	Shelby County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14960	Stark County, Illinois	14	Rural	0.8340	0.8886	37900	Urban	0.8613
14970	Stephenson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14980	Tazewell County, Illinois	6120	Urban	0.8886	0.8886	37900	Urban	0.8886
14981	Union County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14982	Vermilion County, Illinois	14	Rural	0.8340	0.8392	19180	Urban	0.8366
14983	Wabash County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14984	Warren County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14985	Washington County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14986	Wayne County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14987	White County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14988	Whiteside County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14989	Will County, Illinois	1600	Urban	1.0851	1.0868	16974	Urban	1.0860
14990	Williamson County, Illinois	14	Rural	0.8340	0.8339	99914	Rural	0.8340
14991	Winnebago County, Illinois	6880	Urban	0.9626	0.9626	40420	Urban	0.9626
14992	Woodford County, Illinois	6120	Urban	0.8886	0.8886	37900	Urban	0.8886
15000	Adams County, Indiana	2760	Urban	0.9737	0.8653	99915	Rural	0.9195
15010	Allen County, Indiana	2760	Urban	0.9737	0.9807	23060	Urban	0.9772
15020	Bartholomew County, Indiana	15	Rural	0.8736	0.9388	18020	Urban	0.9062
15030	Benton County, Indiana	15	Rural	0.8736	0.9067	29140	Urban	0.8902
15040	Blackford County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15050	Boone County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15060	Brown County, Indiana	15	Rural	0.8736	1.0113	26900	Urban	0.9425
15070	Carroll County, Indiana	15	Rural	0.8736	0.9067	29140	Urban	0.8902
15080	Cass County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15090	Clark County, Indiana	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
15100	Clay County, Indiana	8320	Urban	0.8582	0.8517	45460	Urban	0.8550
15110	Clinton County, Indiana	3920	Urban	0.9067	0.8653	99915	Rural	0.8860
15120	Crawford County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15130	Daviess County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15140	Dearborn County, Indiana	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
15150	Decatur County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15160	De Kalb County, Indiana	2760	Urban	0.9737	0.8653	99915	Rural	0.9195
15170	Delaware County, Indiana	5280	Urban	0.8580	0.8580	34620	Urban	0.8580

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15180	Dubois County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15190	Elkhart County, Indiana	2330	Urban	0.9278	0.9278	21140	Urban	0.9278
15200	Fayette County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15210	Floyd County, Indiana	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
15220	Fountain County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15230	Franklin County, Indiana	15	Rural	0.8736	0.9516	17140	Urban	0.9126
15240	Fulton County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15250	Gibson County, Indiana	15	Rural	0.8736	0.8372	21780	Urban	0.8554
15260	Grant County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15270	Greene County, Indiana	15	Rural	0.8736	0.8587	14020	Urban	0.8662
15280	Hamilton County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15290	Hancock County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15300	Harrison County, Indiana	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
15310	Hendricks County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15320	Henry County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15330	Howard County, Indiana	3850	Urban	0.8986	0.8986	29020	Urban	0.8986
15340	Huntington County, Indiana	2760	Urban	0.9737	0.8653	99915	Rural	0.9195
15350	Jackson County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15360	Jasper County, Indiana	15	Rural	0.8736	0.9310	23844	Urban	0.9023
15370	Jay County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15380	Jefferson County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15390	Jennings County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15400	Johnson County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15410	Knox County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15420	Kosciusko County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15430	Lagrange County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15440	Lake County, Indiana	2960	Urban	0.9342	0.9310	23844	Urban	0.9326
15450	La Porte County, Indiana	15	Rural	0.8736	0.9332	33140	Urban	0.9034
15460	Lawrence County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15470	Madison County, Indiana	3480	Urban	1.0039	0.8713	11300	Urban	0.9376
15480	Marion County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15490	Marshall County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15500	Martin County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15510	Miami County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15520	Monroe County, Indiana	1020	Urban	0.8587	0.8587	14020	Urban	0.8587
15530	Montgomery County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15540	Morgan County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15550	Newton County, Indiana	15	Rural	0.8736	0.9310	23844	Urban	0.9023
15560	Noble County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15570	Ohio County, Indiana	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
15580	Orange County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15590	Owen County, Indiana	15	Rural	0.8736	0.8587	14020	Urban	0.8662
15600	Parke County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695

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15610	Perry County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15620	Pike County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15630	Porter County, Indiana	2960	Urban	0.9342	0.9310	23844	Urban	0.9326
15640	Posey County, Indiana	2440	Urban	0.8395	0.8372	21780	Urban	0.8384
15650	Pulaski County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15660	Putnam County, Indiana	15	Rural	0.8736	1.0113	26900	Urban	0.9425
15670	Randolph County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15680	Ripley County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15690	Rush County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15700	St Joseph County, Indiana	7800	Urban	0.9447	0.9447	43780	Urban	0.9447
15710	Scott County, Indiana	4520	Urban	0.9162	0.8653	99915	Rural	0.8908
15720	Shelby County, Indiana	3480	Urban	1.0039	1.0113	26900	Urban	1.0076
15730	Spencer County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15740	Starke County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15750	Steuben County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15760	Sullivan County, Indiana	15	Rural	0.8736	0.8517	45460	Urban	0.8627
15770	Switzerland County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15780	Tippecanoe County, Indiana	3920	Urban	0.9067	0.9067	29140	Urban	0.9067
15790	Tipton County, Indiana	3850	Urban	0.8986	0.8986	29020	Urban	0.8986
15800	Union County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15810	Vanderburgh County, Indiana	2440	Urban	0.8395	0.8372	21780	Urban	0.8384
15820	Vermillion County, Indiana	8320	Urban	0.8582	0.8517	45460	Urban	0.8550
15830	Vigo County, Indiana	8320	Urban	0.8582	0.8517	45460	Urban	0.8550
15840	Wabash County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15850	Warren County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15860	Warrick County, Indiana	2440	Urban	0.8395	0.8372	21780	Urban	0.8384
15870	Washington County, Indiana	15	Rural	0.8736	0.9122	31140	Urban	0.8929
15880	Wayne County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15890	Wells County, Indiana	2760	Urban	0.9737	0.9807	23060	Urban	0.9772
15900	White County, Indiana	15	Rural	0.8736	0.8653	99915	Rural	0.8695
15910	Whitley County, Indiana	2760	Urban	0.9737	0.9807	23060	Urban	0.9772
16000	Adair County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16010	Adams County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16020	Allamakee County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16030	Appanoose County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16040	Audubon County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16050	Benton County, Iowa	16	Rural	0.8550	0.8975	16300	Urban	0.8763
16060	Black Hawk County, Iowa	8920	Urban	0.8633	0.8633	47940	Urban	0.8633
16070	Boone County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16080	Bremer County, Iowa	16	Rural	0.8550	0.8633	47940	Urban	0.8592
16090	Buchanan County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16100	Buena Vista County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16110	Butler County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513

SSA State/County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
16120	Calhoun County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16130	Carroll County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16140	Cass County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16150	Cedar County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16160	Cerro Gordo County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16170	Cherokee County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16180	Chickasaw County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16190	Clarke County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16200	Clay County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16210	Clayton County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16220	Clinton County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16230	Crawford County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16240	Dallas County, Iowa	2120	Urban	0.9266	0.9266	19780	Urban	0.9266
16250	Davis County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16260	Decatur County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16270	Delaware County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16280	Des Moines County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16290	Dickinson County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16300	Dubuque County, Iowa	2200	Urban	0.8748	0.8748	20220	Urban	0.8748
16310	Emmet County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16320	Fayette County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16330	Floyd County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16340	Franklin County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16350	Fremont County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16360	Greene County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16370	Grundy County, Iowa	16	Rural	0.8550	0.8633	47940	Urban	0.8592
16380	Guthrie County, Iowa	16	Rural	0.8550	0.9266	19780	Urban	0.8908
16390	Hamilton County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16400	Hancock County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16410	Hardin County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16420	Harrison County, Iowa	16	Rural	0.8550	0.9754	36540	Urban	0.9152
16430	Henry County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16440	Howard County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16450	Humboldt County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16460	Ida County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16470	Iowa County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16480	Jackson County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16490	Jasper County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16500	Jefferson County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16510	Johnson County, Iowa	3500	Urban	0.9654	0.9654	26980	Urban	0.9654
16520	Jones County, Iowa	16	Rural	0.8550	0.8975	16300	Urban	0.8763
16530	Keokuk County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16540	Kossuth County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
16550	Lee County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16560	Linn County, Iowa	1360	Urban	0.8975	0.8975	16300	Urban	0.8975
16570	Louisa County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16580	Lucas County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16590	Lyon County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16600	Madison County, Iowa	16	Rural	0.8550	0.9266	19780	Urban	0.8908
16610	Mahaska County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16620	Marion County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16630	Marshall County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16640	Mills County, Iowa	16	Rural	0.8550	0.9754	36540	Urban	0.9152
16650	Mitchell County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16660	Monona County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16670	Monroe County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16680	Montgomery County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16690	Muscatine County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16700	O'Brien County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16710	Osceola County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16720	Page County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16730	Palo Alto County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16740	Plymouth County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16750	Pocahontas County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16760	Polk County, Iowa	2120	Urban	0.9266	0.9266	19780	Urban	0.9266
16770	Pottawattamie County, Iowa	5920	Urban	0.9754	0.9754	36540	Urban	0.9754
16780	Poweshiek County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16790	Ringgold County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16800	Sac County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16810	Scott County, Iowa	1960	Urban	0.8773	0.8773	19340	Urban	0.8773
16820	Shelby County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16830	Sioux County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16840	Story County, Iowa	16	Rural	0.8550	0.9479	11180	Urban	0.9015
16850	Tama County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16860	Taylor County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16870	Union County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16880	Van Buren County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16890	Wapello County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16900	Warren County, Iowa	2120	Urban	0.9266	0.9266	19780	Urban	0.9266
16910	Washington County, Iowa	16	Rural	0.8550	0.9654	26980	Urban	0.9102
16920	Wayne County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16930	Webster County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16940	Winnebago County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16950	Winneshiek County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
16960	Woodbury County, Iowa	7720	Urban	0.9094	0.9070	43580	Urban	0.9082
16970	Worth County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513

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16980	Wright County, Iowa	16	Rural	0.8550	0.8475	99916	Rural	0.8513
17000	Allen County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17010	Anderson County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17020	Atchison County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17030	Barber County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17040	Barton County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17050	Bourbon County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17060	Brown County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17070	Butler County, Kansas	9040	Urban	0.9486	0.9457	48620	Urban	0.9472
17080	Chase County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17090	Chautauqua County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17100	Cherokee County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17110	Cheyenne County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17120	Clark County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17130	Clay County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17140	Cloud County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17150	Coffey County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17160	Comanche County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17170	Cowley County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17180	Crawford County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17190	Decatur County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17200	Dickinson County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17210	Doniphan County, Kansas	17	Rural	0.8087	1.0013	41140	Urban	0.9050
17220	Douglas County, Kansas	4150	Urban	0.8644	0.8644	29940	Urban	0.8644
17230	Edwards County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17240	Elk County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17250	Ellis County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17260	Ellsworth County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17270	Finney County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17280	Ford County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17290	Franklin County, Kansas	17	Rural	0.8087	0.9629	28140	Urban	0.8858
17300	Geary County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17310	Gove County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17320	Graham County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17330	Grant County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17340	Gray County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17350	Greeley County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17360	Greenwood County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17370	Hamilton County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17380	Harper County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17390	Harvey County, Kansas	9040	Urban	0.9486	0.9457	48620	Urban	0.9472
17391	Haskell County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17410	Hodgeman County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083

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17420	Jackson County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17430	Jefferson County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17440	Jewell County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17450	Johnson County, Kansas	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
17451	Kearny County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17470	Kingman County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17480	Kiowa County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17490	Labette County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17500	Lane County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17510	Leavenworth County, Kansas	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
17520	Lincoln County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17530	Linn County, Kansas	17	Rural	0.8087	0.9629	28140	Urban	0.8858
17540	Logan County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17550	Lyon County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17560	Mc Pherson County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17570	Marion County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17580	Marshall County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17590	Meade County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17600	Miami County, Kansas	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
17610	Mitchell County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17620	Montgomery County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17630	Morris County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17640	Morton County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17650	Nemaha County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17660	Neosho County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17670	Ness County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17680	Norton County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17690	Osage County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17700	Osborne County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17710	Ottawa County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17720	Pawnee County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17730	Phillips County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17740	Pottawatomie County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17750	Pratt County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17760	Rawlins County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17770	Reno County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17780	Republic County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17790	Rice County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17800	Riley County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17810	Rooks County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17820	Rush County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17830	Russell County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17840	Saline County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083

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17841	Scott County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17860	Sedgwick County, Kansas	9040	Urban	0.9486	0.9457	48620	Urban	0.9472
17870	Seward County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17880	Shawnee County, Kansas	8440	Urban	0.8904	0.8904	45820	Urban	0.8904
17890	Sheridan County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17900	Sherman County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17910	Smith County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17920	Stafford County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17921	Stanton County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17940	Stevens County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17950	Sumner County, Kansas	17	Rural	0.8087	0.9457	48620	Urban	0.8772
17960	Thomas County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17970	Trego County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17980	Wabaunsee County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17981	Wallace County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17982	Washington County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17983	Wichita County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17984	Wilson County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17985	Woodson County, Kansas	17	Rural	0.8087	0.8079	99917	Rural	0.8083
17986	Wyandotte County, Kansas	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
18000	Adair County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18010	Allen County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18020	Anderson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18030	Ballard County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18040	Barren County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18050	Bath County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18060	Bell County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18070	Boone County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18080	Bourbon County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
18090	Boyd County, Kentucky	3400	Urban	0.9564	0.9564	26580	Urban	0.9564
18100	Boyle County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18110	Bracken County, Kentucky	18	Rural	0.7844	0.9516	17140	Urban	0.8680
18120	Breathitt County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18130	Breckinridge County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18140	Bullitt County, Kentucky	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
18150	Butler County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18160	Caldwell County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18170	Calloway County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18180	Campbell County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18190	Carlisle County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18191	Carroll County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18210	Carter County, Kentucky	3400	Urban	0.9564	0.7755	99918	Rural	0.8660
18220	Casey County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800

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18230	Christian County, Kentucky	1660	Urban	0.8022	0.8022	17300	Urban	0.8022
18240	Clark County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
18250	Clay County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18260	Clinton County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18270	Crittenden County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18271	Cumberland County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18290	Daviess County, Kentucky	5990	Urban	0.8434	0.8434	36980	Urban	0.8434
18291	Edmonson County, Kentucky	18	Rural	0.7844	0.8140	14540	Urban	0.7992
18310	Elliott County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18320	Estill County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18330	Fayette County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
18340	Fleming County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18350	Floyd County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18360	Franklin County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18361	Fulton County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18362	Gallatin County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18390	Garrard County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18400	Grant County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18410	Graves County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18420	Grayson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18421	Green County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18440	Greenup County, Kentucky	3400	Urban	0.9564	0.9564	26580	Urban	0.9564
18450	Hancock County, Kentucky	18	Rural	0.7844	0.8434	36980	Urban	0.8139
18460	Hardin County, Kentucky	18	Rural	0.7844	0.8684	21060	Urban	0.8264
18470	Harlan County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18480	Harrison County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18490	Hart County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18500	Henderson County, Kentucky	2440	Urban	0.8395	0.8372	21780	Urban	0.8384
18510	Henry County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18511	Hickman County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18530	Hopkins County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18540	Jackson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18550	Jefferson County, Kentucky	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
18560	Jessamine County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
18570	Johnson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18580	Kenton County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18590	Knott County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18600	Knox County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18610	Larue County, Kentucky	18	Rural	0.7844	0.8684	21060	Urban	0.8264
18620	Laurel County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18630	Lawrence County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18640	Lee County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18650	Leslie County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800

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18660	Letcher County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18670	Lewis County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18680	Lincoln County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18690	Livingston County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18700	Logan County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18710	Lyon County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18720	Mc Cracken County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18730	Mc Creary County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18740	Mc Lean County, Kentucky	18	Rural	0.7844	0.8434	36980	Urban	0.8139
18750	Madison County, Kentucky	4280	Urban	0.9219	0.7755	99918	Rural	0.8487
18760	Magoffin County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18770	Marion County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18780	Marshall County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18790	Martin County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18800	Mason County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18801	Meade County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18802	Menifee County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18830	Mercer County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18831	Metcalfe County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18850	Monroe County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18860	Montgomery County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18861	Morgan County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18880	Muhlenberg County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18890	Nelson County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18900	Nicholas County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18910	Ohio County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18920	Oldham County, Kentucky	4520	Urban	0.9162	0.9122	31140	Urban	0.9142
18930	Owen County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18931	Owsley County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18932	Pendleton County, Kentucky	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
18960	Perry County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18970	Pike County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18971	Powell County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18972	Pulaski County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18973	Robertson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18974	Rockcastle County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18975	Rowan County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18976	Russell County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18977	Scott County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
18978	Shelby County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18979	Simpson County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18980	Spencer County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18981	Taylor County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
18982	Todd County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18983	Trigg County, Kentucky	18	Rural	0.7844	0.8022	17300	Urban	0.7933
18984	Trimble County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18985	Union County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18986	Warren County, Kentucky	18	Rural	0.7844	0.8140	14540	Urban	0.7992
18987	Washington County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18988	Wayne County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18989	Webster County, Kentucky	18	Rural	0.7844	0.8372	21780	Urban	0.8108
18990	Whitley County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18991	Wolfe County, Kentucky	18	Rural	0.7844	0.7755	99918	Rural	0.7800
18992	Woodford County, Kentucky	4280	Urban	0.9219	0.9359	30460	Urban	0.9289
19000	Acadia County, Louisiana	3880	Urban	0.8105	0.7345	99919	Rural	0.7725
19010	Allen County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19020	Ascension County, Louisiana	0760	Urban	0.8354	0.8319	12940	Urban	0.8337
19030	Assumption County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19040	Avoyelles County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19050	Beauregard County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19060	Bienville County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19070	Bossier County, Louisiana	7680	Urban	0.9111	0.9132	43340	Urban	0.9122
19080	Caddo County, Louisiana	7680	Urban	0.9111	0.9132	43340	Urban	0.9122
19090	Calcasieu County, Louisiana	3960	Urban	0.7972	0.7935	29340	Urban	0.7954
19100	Caldwell County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19110	Cameron County, Louisiana	19	Rural	0.7290	0.7935	29340	Urban	0.7613
19120	Catahoula County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19130	Claiborne County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19140	Concordia County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19150	De Soto County, Louisiana	19	Rural	0.7290	0.9132	43340	Urban	0.8211
19160	East Baton Rouge County, Louisiana	0760	Urban	0.8354	0.8319	12940	Urban	0.8337
19170	East Carroll County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19180	East Feliciana County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19190	Evangeline County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19200	Franklin County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19210	Grant County, Louisiana	19	Rural	0.7290	0.8171	10780	Urban	0.7731
19220	Iberia County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19230	Iberville County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19240	Jackson County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19250	Jefferson County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19260	Jefferson Davis County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19270	Lafayette County, Louisiana	3880	Urban	0.8105	0.8306	29180	Urban	0.8206
19280	Lafourche County, Louisiana	3350	Urban	0.7721	0.7721	26380	Urban	0.7721
19290	La Salle County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19300	Lincoln County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19310	Livingston County, Louisiana	0760	Urban	0.8354	0.8319	12940	Urban	0.8337

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19320	Madison County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19330	Morehouse County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19340	Natchitoches County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19350	Orleans County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19360	Ouachita County, Louisiana	5200	Urban	0.7913	0.7903	33740	Urban	0.7908
19370	Plaquemines County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19380	Pointe Coupee County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19390	Rapides County, Louisiana	0220	Urban	0.8171	0.8171	10780	Urban	0.8171
19400	Red River County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19410	Richland County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19420	Sabine County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19430	St Bernard County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19440	St Charles County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19450	St Helena County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19460	St James County, Louisiana	5560	Urban	0.9103	0.7345	99919	Rural	0.8224
19470	St John Baptist County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19480	St Landry County, Louisiana	3880	Urban	0.8105	0.7345	99919	Rural	0.7725
19490	St Martin County, Louisiana	3880	Urban	0.8105	0.8306	29180	Urban	0.8206
19500	St Mary County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19510	St Tammany County, Louisiana	5560	Urban	0.9103	0.9103	35380	Urban	0.9103
19520	Tangipahoa County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19530	Tensas County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19540	Terrebonne County, Louisiana	3350	Urban	0.7721	0.7721	26380	Urban	0.7721
19550	Union County, Louisiana	19	Rural	0.7290	0.7903	33740	Urban	0.7597
19560	Vermilion County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19570	Vernon County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19580	Washington County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19590	Webster County, Louisiana	7680	Urban	0.9111	0.7345	99919	Rural	0.8228
19600	West Baton Rouge County, Louisiana	0760	Urban	0.8354	0.8319	12940	Urban	0.8337
19610	West Carroll County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
19620	West Feliciana County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19630	Winn County, Louisiana	19	Rural	0.7290	0.7345	99919	Rural	0.7318
20000	Androscoggin County, Maine	4243	Urban	0.9562	0.9562	30340	Urban	0.9562
20010	Aroostook County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20020	Cumberland County, Maine	6403	Urban	1.0112	1.0112	38860	Urban	1.0112
20030	Franklin County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20040	Hancock County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20050	Kennebec County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20060	Knox County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20070	Lincoln County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20080	Oxford County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20090	Penobscot County, Maine	0733	Urban	0.9955	0.9955	12620	Urban	0.9955
20100	Piscataquis County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039

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20110	Sagadahoc County, Maine	6403	Urban	1.0112	1.0112	38860	Urban	1.0112
20120	Somerset County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20130	Waldo County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20140	Washington County, Maine	20	Rural	0.9039	0.9039	99920	Rural	0.9039
20150	York County, Maine	6403	Urban	1.0112	1.0112	38860	Urban	1.0112
21000	Allegany County, Maryland	1900	Urban	0.8662	0.8662	19060	Urban	0.8662
21010	Anne Arundel County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21020	Baltimore County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21030	Baltimore City County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21040	Calvert County, Maryland	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
21050	Caroline County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21060	Carroll County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21070	Cecil County, Maryland	9160	Urban	1.1121	1.1049	48864	Urban	1.1085
21080	Charles County, Maryland	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
21090	Dorchester County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21100	Frederick County, Maryland	8840	Urban	1.0971	1.0956	13644	Urban	1.0964
21110	Garrett County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21120	Harford County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21130	Howard County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21140	Kent County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21150	Montgomery County, Maryland	8840	Urban	1.0971	1.0956	13644	Urban	1.0964
21160	Prince Georges County, Maryland	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
21170	Queen Annes County, Maryland	0720	Urban	0.9907	0.9907	12580	Urban	0.9907
21180	St Marys County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21190	Somerset County, Maryland	21	Rural	0.9179	0.9123	41540	Urban	0.9151
21200	Talbot County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
21210	Washington County, Maryland	3180	Urban	0.9940	0.9715	25180	Urban	0.9828
21220	Wicomico County, Maryland	21	Rural	0.9179	0.9123	41540	Urban	0.9151
21230	Worcester County, Maryland	21	Rural	0.9179	0.9220	99921	Rural	0.9200
22000	Barnstable County, Massachusetts	0743	Urban	1.2335	1.2335	12700	Urban	1.2335
22010	Berkshire County, Massachusetts	6323	Urban	1.0439	1.0439	38340	Urban	1.0439
22020	Bristol County, Massachusetts	1123	Urban	1.1290	1.0929	39300	Urban	1.1110
22030	Dukes County, Massachusetts	22	Rural	1.0216	1.0216	99922	Rural	1.0216
22040	Essex County, Massachusetts	1123	Urban	1.1290	1.0662	21604	Urban	1.0976
22060	Franklin County, Massachusetts	22	Rural	1.0216	1.0176	44140	Urban	1.0196
22070	Hampden County, Massachusetts	8003	Urban	1.0173	1.0176	44140	Urban	1.0175
22080	Hampshire County, Massachusetts	8003	Urban	1.0173	1.0176	44140	Urban	1.0175
22090	Middlesex County, Massachusetts	1123	Urban	1.1290	1.1189	15764	Urban	1.1240
22120	Nantucket County, Massachusetts	22	Rural	1.0216	1.0216	99922	Rural	1.0216
22130	Norfolk County, Massachusetts	1123	Urban	1.1290	1.1771	14484	Urban	1.1531
22150	Plymouth County, Massachusetts	1123	Urban	1.1290	1.1771	14484	Urban	1.1531
22160	Suffolk County, Massachusetts	1123	Urban	1.1290	1.1771	14484	Urban	1.1531
22170	Worcester County, Massachusetts	1123	Urban	1.1290	1.0996	49340	Urban	1.1143

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
23000	Alcona County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23010	Alger County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23020	Allegan County, Michigan	3000	Urban	0.9519	0.8786	99923	Rural	0.9153
23030	Alpena County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23040	Antrim County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23050	Arenac County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23060	Baraga County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23070	Barry County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
23080	Bay County, Michigan	6960	Urban	0.9696	0.9574	13020	Urban	0.9635
23090	Benzie County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23100	Berrien County, Michigan	0870	Urban	0.8847	0.8847	35660	Urban	0.8847
23110	Branch County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23120	Calhoun County, Michigan	3720	Urban	1.0350	0.9366	12980	Urban	0.9858
23130	Cass County, Michigan	23	Rural	0.8740	0.9447	43780	Urban	0.9094
23140	Charlevoix County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23150	Cheboygan County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23160	Chippewa County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23170	Clare County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23180	Clinton County, Michigan	4040	Urban	0.9658	0.9658	29620	Urban	0.9658
23190	Crawford County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23200	Delta County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23210	Dickinson County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23220	Eaton County, Michigan	4040	Urban	0.9658	0.9658	29620	Urban	0.9658
23230	Emmet County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23240	Genesee County, Michigan	2640	Urban	1.1178	1.1178	22420	Urban	1.1178
23250	Gladwin County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23260	Gogebic County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23270	Grand Traverse County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23280	Gratiot County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23290	Hillsdale County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23300	Houghton County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23310	Huron County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23320	Ingham County, Michigan	4040	Urban	0.9658	0.9658	29620	Urban	0.9658
23330	Ionia County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
23340	Iosco County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23350	Iron County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23360	Isabella County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23370	Jackson County, Michigan	3520	Urban	0.9146	0.9146	27100	Urban	0.9146
23380	Kalamazoo County, Michigan	3720	Urban	1.0350	1.0676	28020	Urban	1.0513
23390	Kalkaska County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23400	Kent County, Michigan	3000	Urban	0.9519	0.9420	24340	Urban	0.9470
23410	Keweenaw County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23420	Lake County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763

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23430	Lapeer County, Michigan	2160	Urban	1.0227	1.0112	47644	Urban	1.0170
23440	Leelanau County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23450	Lenawee County, Michigan	0440	Urban	1.0816	0.8786	99923	Rural	0.9801
23460	Livingston County, Michigan	0440	Urban	1.0816	1.0112	47644	Urban	1.0464
23470	Luce County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23480	Mackinac County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23490	Macomb County, Michigan	2160	Urban	1.0227	1.0112	47644	Urban	1.0170
23500	Manistee County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23510	Marquette County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23520	Mason County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23530	Mecosta County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23540	Menominee County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23550	Midland County, Michigan	6960	Urban	0.9696	0.8786	99923	Rural	0.9241
23560	Missaukee County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23570	Monroe County, Michigan	2160	Urban	1.0227	0.9506	33780	Urban	0.9867
23580	Montcalm County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23590	Montmorency County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23600	Muskegon County, Michigan	3000	Urban	0.9519	0.9741	34740	Urban	0.9630
23610	Newaygo County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
23620	Oakland County, Michigan	2160	Urban	1.0227	1.0112	47644	Urban	1.0170
23630	Oceana County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23640	Ogemaw County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23650	Ontonagon County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23660	Osceola County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23670	Oscoda County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23680	Otsego County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23690	Ottawa County, Michigan	3000	Urban	0.9519	0.9388	26100	Urban	0.9454
23700	Presque Isle County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23710	Roscommon County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23720	Saginaw County, Michigan	6960	Urban	0.9696	0.9814	40980	Urban	0.9755
23730	St Clair County, Michigan	2160	Urban	1.0227	1.0112	47644	Urban	1.0170
23740	St Joseph County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23750	Sanilac County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23760	Schoolcraft County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23770	Shiawassee County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23780	Tuscola County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
23790	Van Buren County, Michigan	3720	Urban	1.0350	1.0676	28020	Urban	1.0513
23800	Washtenaw County, Michigan	0440	Urban	1.0816	1.1022	11460	Urban	1.0919
23810	Wayne County, Michigan	2160	Urban	1.0227	1.0349	19804	Urban	1.0288
23830	Wexford County, Michigan	23	Rural	0.8740	0.8786	99923	Rural	0.8763
24000	Aitkin County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24010	Anoka County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24020	Becker County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335

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24030	Beltrami County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24040	Benton County, Minnesota	6980	Urban	1.0215	1.0215	41060	Urban	1.0215
24050	Big Stone County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24060	Blue Earth County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24070	Brown County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24080	Carlton County, Minnesota	24	Rural	0.9339	1.0340	20260	Urban	0.9840
24090	Carver County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24100	Cass County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24110	Chippewa County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24120	Chisago County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24130	Clay County, Minnesota	2520	Urban	0.9114	0.9114	22020	Urban	0.9114
24140	Clearwater County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24150	Cook County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24160	Cottonwood County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24170	Crow Wing County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24180	Dakota County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24190	Dodge County, Minnesota	24	Rural	0.9339	1.1504	40340	Urban	1.0422
24200	Douglas County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24210	Faribault County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24220	Fillmore County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24230	Freeborn County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24240	Goodhue County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24250	Grant County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24260	Hennepin County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24270	Houston County, Minnesota	3870	Urban	0.9289	0.9289	29100	Urban	0.9289
24280	Hubbard County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24290	Isanti County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24300	Itasca County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24310	Jackson County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24320	Kanabec County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24330	Kandiyohi County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24340	Kittson County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24350	Koochiching County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24360	Lac Qui Parle County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24370	Lake County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24380	Lake Of Woods County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24390	Le Sueur County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24400	Lincoln County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24410	Lyon County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24420	Mc Leod County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24430	Mahnomen County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24440	Marshall County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24450	Martin County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335

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24460	Meeker County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24470	Mille Lacs County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24480	Morrison County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24490	Mower County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24500	Murray County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24510	Nicollet County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24520	Nobles County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24530	Norman County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24540	Olmsted County, Minnesota	6820	Urban	1.1504	1.1504	40340	Urban	1.1504
24550	Otter Tail County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24560	Pennington County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24570	Pine County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24580	Pipestone County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24590	Polk County, Minnesota	2985	Urban	0.9091	0.9091	24220	Urban	0.9091
24600	Pope County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24610	Ramsey County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24620	Red Lake County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24630	Redwood County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24640	Renville County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24650	Rice County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24660	Rock County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24670	Roseau County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24680	St Louis County, Minnesota	2240	Urban	1.0356	1.0340	20260	Urban	1.0348
24690	Scott County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24700	Sherburne County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24710	Sibley County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24720	Stearns County, Minnesota	6980	Urban	1.0215	1.0215	41060	Urban	1.0215
24730	Steele County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24740	Stevens County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24750	Swift County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24760	Todd County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24770	Traverse County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24780	Wabasha County, Minnesota	24	Rural	0.9339	1.1504	40340	Urban	1.0422
24790	Wadena County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24800	Waseca County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24810	Washington County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24820	Watsonwan County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24830	Wilkin County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24840	Winona County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
24850	Wright County, Minnesota	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
24860	Yellow Medicine County, Minnesota	24	Rural	0.9339	0.9330	99924	Rural	0.9335
25000	Adams County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25010	Alcorn County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609

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25020	Amite County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25030	Attala County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25040	Benton County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25050	Bolivar County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25060	Calhoun County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25070	Carroll County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25080	Chickasaw County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25090	Choctaw County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25100	Claiborne County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25110	Clarke County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25120	Clay County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25130	Coahoma County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25140	Copiah County, Mississippi	25	Rural	0.7583	0.8291	27140	Urban	0.7937
25150	Covington County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25160	Desoto County, Mississippi	4920	Urban	0.9234	0.9217	32820	Urban	0.9226
25170	Forrest County, Mississippi	3285	Urban	0.7362	0.7362	25620	Urban	0.7362
25180	Franklin County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25190	George County, Mississippi	25	Rural	0.7583	0.7974	37700	Urban	0.7779
25200	Greene County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25210	Grenada County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25220	Hancock County, Mississippi	0920	Urban	0.8649	0.8950	25060	Urban	0.8800
25230	Harrison County, Mississippi	0920	Urban	0.8649	0.8950	25060	Urban	0.8800
25240	Hinds County, Mississippi	3560	Urban	0.8406	0.8291	27140	Urban	0.8349
25250	Holmes County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25260	Humphreys County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25270	Issaquena County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25280	Itawamba County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25290	Jackson County, Mississippi	0920	Urban	0.8649	0.7974	37700	Urban	0.8312
25300	Jasper County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25310	Jefferson County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25320	Jefferson Davis County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25330	Jones County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25340	Kemper County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25350	Lafayette County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25360	Lamar County, Mississippi	3285	Urban	0.7362	0.7362	25620	Urban	0.7362
25370	Lauderdale County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25380	Lawrence County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25390	Leake County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25400	Lee County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25410	Leflore County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25420	Lincoln County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25430	Lowndes County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25440	Madison County, Mississippi	3560	Urban	0.8406	0.8291	27140	Urban	0.8349

SSA State/County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
25450	Marion County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25460	Marshall County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
25470	Monroe County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25480	Montgomery County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25490	Neshoba County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25500	Newton County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25510	Noxubee County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25520	Oktibbeha County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25530	Panola County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25540	Pearl River County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25550	Perry County, Mississippi	25	Rural	0.7583	0.7362	25620	Urban	0.7473
25560	Pike County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25570	Pontotoc County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25580	Prentiss County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25590	Quitman County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25600	Rankin County, Mississippi	3560	Urban	0.8406	0.8291	27140	Urban	0.8349
25610	Scott County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25620	Sharkey County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25630	Simpson County, Mississippi	25	Rural	0.7583	0.8291	27140	Urban	0.7937
25640	Smith County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25650	Stone County, Mississippi	25	Rural	0.7583	0.8950	25060	Urban	0.8267
25660	Sunflower County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25670	Tallahatchie County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25680	Tate County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
25690	Tippah County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25700	Tishomingo County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25710	Tunica County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
25720	Union County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25730	Walthall County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25740	Warren County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25750	Washington County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25760	Wayne County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25770	Webster County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25780	Wilkinson County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25790	Winston County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25800	Yalobusha County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
25810	Yazoo County, Mississippi	25	Rural	0.7583	0.7635	99925	Rural	0.7609
26000	Adair County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26010	Andrew County, Missouri	7000	Urban	1.0013	1.0013	41140	Urban	1.0013
26020	Atchison County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26030	Audrain County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26040	Barry County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26050	Barton County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796

SSA State/County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
26060	Bates County, Missouri	26	Rural	0.7829	0.9629	28140	Urban	0.8729
26070	Benton County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26080	Bollinger County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26090	Boone County, Missouri	1740	Urban	0.8396	0.8396	17860	Urban	0.8396
26100	Buchanan County, Missouri	7000	Urban	1.0013	1.0013	41140	Urban	1.0013
26110	Butler County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26120	Caldwell County, Missouri	26	Rural	0.7829	0.9629	28140	Urban	0.8729
26130	Callaway County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26140	Camden County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26150	Cape Girardeau County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26160	Carroll County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26170	Carter County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26180	Cass County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26190	Cedar County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26200	Chariton County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26210	Christian County, Missouri	7920	Urban	0.8597	0.8557	44180	Urban	0.8577
26220	Clark County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26230	Clay County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26240	Clinton County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26250	Cole County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26260	Cooper County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26270	Crawford County, Missouri	26	Rural	0.7829	0.9076	41180	Urban	0.8453
26280	Dade County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26290	Dallas County, Missouri	26	Rural	0.7829	0.8557	44180	Urban	0.8193
26300	Daviess County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26310	De Kalb County, Missouri	26	Rural	0.7829	1.0013	41140	Urban	0.8921
26320	Dent County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26330	Douglas County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26340	Dunklin County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26350	Franklin County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26360	Gasconade County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26370	Gentry County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26380	Greene County, Missouri	7920	Urban	0.8597	0.8557	44180	Urban	0.8577
26390	Grundy County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26400	Harrison County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26410	Henry County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26411	Hickory County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26412	Holt County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26440	Howard County, Missouri	26	Rural	0.7829	0.8396	17860	Urban	0.8113
26450	Howell County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26460	Iron County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26470	Jackson County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26480	Jasper County, Missouri	3710	Urban	0.8721	0.8721	27900	Urban	0.8721

SSA State/County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
26490	Jefferson County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26500	Johnson County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26510	Knox County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26520	Laclede County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26530	Lafayette County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26540	Lawrence County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26541	Lewis County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26560	Lincoln County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26570	Linn County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26580	Livingston County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26590	Mc Donald County, Missouri	26	Rural	0.7829	0.8636	22220	Urban	0.8233
26600	Macon County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26601	Madison County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26620	Maries County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26630	Marion County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26631	Mercer County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26650	Miller County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26660	Mississippi County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26670	Moniteau County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26680	Monroe County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26690	Montgomery County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26700	Morgan County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26710	New Madrid County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26720	Newton County, Missouri	3710	Urban	0.8721	0.8721	27900	Urban	0.8721
26730	Nodaway County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26740	Oregon County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26750	Osage County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26751	Ozark County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26770	Pemiscot County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26780	Perry County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26790	Pettis County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26800	Phelps County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26810	Pike County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26820	Platte County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26821	Polk County, Missouri	26	Rural	0.7829	0.8557	44180	Urban	0.8193
26840	Pulaski County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26850	Putnam County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26860	Ralls County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26870	Randolph County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26880	Ray County, Missouri	3760	Urban	0.9641	0.9629	28140	Urban	0.9635
26881	Reynolds County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26900	Ripley County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26910	St Charles County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079

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26911	St Clair County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26930	St Francois County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26940	St Louis County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26950	St Louis City County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26960	Ste Genevieve County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26970	Saline County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26980	Schuyler County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26981	Scotland County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26982	Scott County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26983	Shannon County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26984	Shelby County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26985	Stoddard County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26986	Stone County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26987	Sullivan County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26988	Taney County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26989	Texas County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26990	Vernon County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26991	Warren County, Missouri	7040	Urban	0.9081	0.9076	41180	Urban	0.9079
26992	Washington County, Missouri	26	Rural	0.7829	0.9076	41180	Urban	0.8453
26993	Wayne County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26994	Webster County, Missouri	7920	Urban	0.8597	0.8557	44180	Urban	0.8577
26995	Worth County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
26996	Wright County, Missouri	26	Rural	0.7829	0.7762	99926	Rural	0.7796
27000	Beaverhead County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27010	Big Horn County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27020	Blaine County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27030	Broadwater County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27040	Carbon County, Montana	27	Rural	0.8701	0.8961	13740	Urban	0.8831
27050	Carter County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27060	Cascade County, Montana	3040	Urban	0.8810	0.8810	24500	Urban	0.8810
27070	Chouteau County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27080	Custer County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27090	Daniels County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27100	Dawson County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27110	Deer Lodge County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27113	Yellowstone National Park, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27120	Fallon County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27130	Fergus County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27140	Flathead County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27150	Gallatin County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27160	Garfield County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27170	Glacier County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27180	Golden Valley County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701

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27190	Granite County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27200	Hill County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27210	Jefferson County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27220	Judith Basin County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27230	Lake County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27240	Lewis And Clark County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27250	Liberty County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27260	Lincoln County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27270	Mc Cone County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27280	Madison County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27290	Meagher County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27300	Mineral County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27310	Missoula County, Montana	5140	Urban	0.9618	0.9618	33540	Urban	0.9618
27320	Musselshell County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27330	Park County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27340	Petroleum County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27350	Phillips County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27360	Pondera County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27370	Powder River County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27380	Powell County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27390	Prairie County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27400	Ravalli County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27410	Richland County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27420	Roosevelt County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27430	Rosebud County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27440	Sanders County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27450	Sheridan County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27460	Silver Bow County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27470	Stillwater County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27480	Sweet Grass County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27490	Teton County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27500	Toole County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27510	Treasure County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27520	Valley County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27530	Wheatland County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27540	Wibaux County, Montana	27	Rural	0.8701	0.8701	99927	Rural	0.8701
27550	Yellowstone County, Montana	0880	Urban	0.8961	0.8961	13740	Urban	0.8961
28000	Adams County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28010	Antelope County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28020	Arthur County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28030	Banner County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28040	Blaine County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28050	Boone County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035

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28060	Box Butte County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28070	Boyd County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28080	Brown County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28090	Buffalo County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28100	Burt County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28110	Butler County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28120	Cass County, Nebraska	5920	Urban	0.9754	0.9754	36540	Urban	0.9754
28130	Cedar County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28140	Chase County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28150	Cherry County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28160	Cheyenne County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28170	Clay County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28180	Colfax County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28190	Cuming County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28200	Custer County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28210	Dakota County, Nebraska	7720	Urban	0.9094	0.9070	43580	Urban	0.9082
28220	Dawes County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28230	Dawson County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28240	Deuel County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28250	Dixon County, Nebraska	28	Rural	0.9035	0.9070	43580	Urban	0.9053
28260	Dodge County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28270	Douglas County, Nebraska	5920	Urban	0.9754	0.9754	36540	Urban	0.9754
28280	Dundy County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28290	Fillmore County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28300	Franklin County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28310	Frontier County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28320	Furnas County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28330	Gage County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28340	Garden County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28350	Garfield County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28360	Gosper County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28370	Grant County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28380	Greeley County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28390	Hall County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28400	Hamilton County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28410	Harlan County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28420	Hayes County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28430	Hitchcock County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28440	Holt County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28450	Hooker County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28460	Howard County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28470	Jefferson County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28480	Johnson County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
28490	Kearney County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28500	Keith County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28510	Keya Paha County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28520	Kimball County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28530	Knox County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28540	Lancaster County, Nebraska	4360	Urban	1.0208	1.0208	30700	Urban	1.0208
28550	Lincoln County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28560	Logan County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28570	Loup County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28580	Mc Pherson County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28590	Madison County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28600	Merrick County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28610	Morrill County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28620	Nance County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28630	Nemaha County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28640	Nuckolls County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28650	Otoe County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28660	Pawnee County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28670	Perkins County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28680	Phelps County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28690	Pierce County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28700	Platte County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28710	Polk County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28720	Redwillow County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28730	Richardson County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28740	Rock County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28750	Saline County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28760	Sarpy County, Nebraska	5920	Urban	0.9754	0.9754	36540	Urban	0.9754
28770	Saunders County, Nebraska	28	Rural	0.9035	0.9754	36540	Urban	0.9395
28780	Scotts Bluff County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28790	Seward County, Nebraska	28	Rural	0.9035	1.0208	30700	Urban	0.9622
28800	Sheridan County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28810	Sherman County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28820	Sioux County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28830	Stanton County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28840	Thayer County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28850	Thomas County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28860	Thurston County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28870	Valley County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28880	Washington County, Nebraska	5920	Urban	0.9754	0.9754	36540	Urban	0.9754
28890	Wayne County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28900	Webster County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
28910	Wheeler County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035

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28920	York County, Nebraska	28	Rural	0.9035	0.9035	99928	Rural	0.9035
29000	Churchill County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29010	Clark County, Nevada	4120	Urban	1.1121	1.1378	29820	Urban	1.1250
29020	Douglas County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29030	Elko County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29040	Esmeralda County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29050	Eureka County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29060	Humboldt County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29070	Lander County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29080	Lincoln County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29090	Lyon County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29100	Mineral County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29110	Nye County, Nevada	4120	Urban	1.1121	0.9280	99929	Rural	1.0201
29120	Carson City County, Nevada	29	Rural	0.9832	1.0352	16180	Urban	1.0092
29130	Pershing County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
29140	Storey County, Nevada	29	Rural	0.9832	1.0456	39900	Urban	1.0144
29150	Washoe County, Nevada	6720	Urban	1.0456	1.0456	39900	Urban	1.0456
29160	White Pine County, Nevada	29	Rural	0.9832	0.9280	99929	Rural	0.9556
30000	Belknap County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
30010	Carroll County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
30020	Cheshire County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
30030	Coos County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
30040	Grafton County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
30050	Hillsboro County, New Hampshire	1123	Urban	1.1290	1.0642	31700	Urban	1.0966
30060	Merrimack County, New Hampshire	1123	Urban	1.1290	1.0642	31700	Urban	1.0966
30070	Rockingham County, New Hampshire	1123	Urban	1.1290	1.0221	40484	Urban	1.0756
30080	Strafford County, New Hampshire	1123	Urban	1.1290	1.0221	40484	Urban	1.0756
30090	Sullivan County, New Hampshire	30	Rural	0.9940	0.9940	99930	Rural	0.9940
31000	Atlantic County, New Jersey	0560	Urban	1.0907	1.0931	12100	Urban	1.0919
31100	Bergen County, New Jersey	0875	Urban	1.1967	1.3311	35644	Urban	1.2639
31150	Burlington County, New Jersey	6160	Urban	1.0824	1.0675	15804	Urban	1.0750
31160	Camden County, New Jersey	6160	Urban	1.0824	1.0675	15804	Urban	1.0750
31180	Cape May County, New Jersey	0560	Urban	1.0907	1.0810	36140	Urban	1.0859
31190	Cumberland County, New Jersey	8760	Urban	1.0573	1.0573	47220	Urban	1.0573
31200	Essex County, New Jersey	5640	Urban	1.1625	1.1687	35084	Urban	1.1656
31220	Gloucester County, New Jersey	6160	Urban	1.0824	1.0675	15804	Urban	1.0750
31230	Hudson County, New Jersey	3640	Urban	1.0923	1.3311	35644	Urban	1.2117
31250	Hunterdon County, New Jersey	5015	Urban	1.1360	1.1687	35084	Urban	1.1524
31260	Mercer County, New Jersey	8480	Urban	1.0276	1.0276	45940	Urban	1.0276
31270	Middlesex County, New Jersey	5015	Urban	1.1360	1.1136	20764	Urban	1.1248
31290	Monmouth County, New Jersey	5190	Urban	1.0888	1.1136	20764	Urban	1.1012
31300	Morris County, New Jersey	5640	Urban	1.1625	1.1687	35084	Urban	1.1656
31310	Ocean County, New Jersey	5190	Urban	1.0888	1.1136	20764	Urban	1.1012

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31320	Passaic County, New Jersey	0875	Urban	1.1967	1.3311	35644	Urban	1.2639
31340	Salem County, New Jersey	6160	Urban	1.0824	1.1049	48864	Urban	1.0937
31350	Somerset County, New Jersey	5015	Urban	1.1360	1.1136	20764	Urban	1.1248
31360	Sussex County, New Jersey	5640	Urban	1.1625	1.1687	35084	Urban	1.1656
31370	Union County, New Jersey	5640	Urban	1.1625	1.1687	35084	Urban	1.1656
31390	Warren County, New Jersey	5640	Urban	1.1625	0.9501	10900	Urban	1.0563
32000	Bernalillo County, New Mexico	0200	Urban	1.0485	1.0485	10740	Urban	1.0485
32010	Catron County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32020	Chaves County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32025	Cibola County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32030	Colfax County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32040	Curry County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32050	De Baca County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32060	Dona Ana County, New Mexico	4100	Urban	0.8784	0.8784	29740	Urban	0.8784
32070	Eddy County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32080	Grant County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32090	Guadalupe County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32100	Harding County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32110	Hidalgo County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32120	Lea County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32130	Lincoln County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32131	Los Alamos County, New Mexico	7490	Urban	1.0590	0.8680	99932	Rural	0.9635
32140	Luna County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32150	Mc Kinley County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32160	Mora County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32170	Otero County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32180	Quay County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32190	Rio Arriba County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32200	Roosevelt County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32210	Sandoval County, New Mexico	0200	Urban	1.0485	1.0485	10740	Urban	1.0485
32220	San Juan County, New Mexico	32	Rural	0.8529	0.8049	22140	Urban	0.8289
32230	San Miguel County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32240	Santa Fe County, New Mexico	7490	Urban	1.0590	1.0909	42140	Urban	1.0750
32250	Sierra County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32260	Socorro County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32270	Taos County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32280	Torrance County, New Mexico	32	Rural	0.8529	1.0485	10740	Urban	0.9507
32290	Union County, New Mexico	32	Rural	0.8529	0.8680	99932	Rural	0.8605
32300	Valencia County, New Mexico	0200	Urban	1.0485	1.0485	10740	Urban	1.0485
33000	Albany County, New York	0160	Urban	0.8570	0.8650	10580	Urban	0.8610
33010	Allegany County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33020	Bronx County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33030	Broome County, New York	0960	Urban	0.8447	0.8447	13780	Urban	0.8447

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33040	Cattaraugus County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33050	Cayuga County, New York	8160	Urban	0.9394	0.8151	99933	Rural	0.8773
33060	Chautauqua County, New York	3610	Urban	0.7589	0.8151	99933	Rural	0.7870
33070	Chemung County, New York	2335	Urban	0.8445	0.8445	21300	Urban	0.8445
33080	Chenango County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33090	Clinton County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33200	Columbia County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33210	Cortland County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33220	Delaware County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33230	Dutchess County, New York	2281	Urban	1.1657	1.1363	39100	Urban	1.1510
33240	Erie County, New York	1280	Urban	0.9339	0.9339	15380	Urban	0.9339
33260	Essex County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33270	Franklin County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33280	Fulton County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33290	Genesee County, New York	6840	Urban	0.9196	0.8151	99933	Rural	0.8674
33300	Greene County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33310	Hamilton County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33320	Herkimer County, New York	8680	Urban	0.8295	0.8295	46540	Urban	0.8295
33330	Jefferson County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33331	Kings County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33340	Lewis County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33350	Livingston County, New York	6840	Urban	0.9196	0.9281	40380	Urban	0.9239
33360	Madison County, New York	8160	Urban	0.9394	0.9468	45060	Urban	0.9431
33370	Monroe County, New York	6840	Urban	0.9196	0.9281	40380	Urban	0.9239
33380	Montgomery County, New York	0160	Urban	0.8570	0.8151	99933	Rural	0.8361
33400	Nassau County, New York	5380	Urban	1.2907	1.2907	35004	Urban	1.2907
33420	New York County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33500	Niagara County, New York	1280	Urban	0.9339	0.9339	15380	Urban	0.9339
33510	Oneida County, New York	8680	Urban	0.8295	0.8295	46540	Urban	0.8295
33520	Onondaga County, New York	8160	Urban	0.9394	0.9468	45060	Urban	0.9431
33530	Ontario County, New York	6840	Urban	0.9196	0.9281	40380	Urban	0.9239
33540	Orange County, New York	5660	Urban	1.1170	1.1363	39100	Urban	1.1267
33550	Orleans County, New York	6840	Urban	0.9196	0.9281	40380	Urban	0.9239
33560	Oswego County, New York	8160	Urban	0.9394	0.9468	45060	Urban	0.9431
33570	Otsego County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33580	Putnam County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33590	Queens County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33600	Rensselaer County, New York	0160	Urban	0.8570	0.8650	10580	Urban	0.8610
33610	Richmond County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33620	Rockland County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33630	St Lawrence County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33640	Saratoga County, New York	0160	Urban	0.8570	0.8650	10580	Urban	0.8610
33650	Schenectady County, New York	0160	Urban	0.8570	0.8650	10580	Urban	0.8610

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
33660	Schoharie County, New York	0160	Urban	0.8570	0.8650	10580	Urban	0.8610
33670	Schuyler County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33680	Seneca County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33690	Steuben County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33700	Suffolk County, New York	5380	Urban	1.2907	1.2907	35004	Urban	1.2907
33710	Sullivan County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33720	Tioga County, New York	0960	Urban	0.8447	0.8447	13780	Urban	0.8447
33730	Tompkins County, New York	33	Rural	0.8403	0.9589	27060	Urban	0.8996
33740	Ulster County, New York	33	Rural	0.8403	0.9000	28740	Urban	0.8702
33750	Warren County, New York	2975	Urban	0.8467	0.8467	24020	Urban	0.8467
33760	Washington County, New York	2975	Urban	0.8467	0.8467	24020	Urban	0.8467
33770	Wayne County, New York	6840	Urban	0.9196	0.9281	40380	Urban	0.9239
33800	Westchester County, New York	5600	Urban	1.3586	1.3311	35644	Urban	1.3449
33900	Wyoming County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
33910	Yates County, New York	33	Rural	0.8403	0.8151	99933	Rural	0.8277
34000	Alamance County, N Carolina	3120	Urban	0.9312	0.8967	15500	Urban	0.9140
34010	Alexander County, N Carolina	3290	Urban	0.9502	0.9502	25860	Urban	0.9502
34020	Alleghany County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34030	Anson County, N Carolina	34	Rural	0.8500	0.9743	16740	Urban	0.9122
34040	Ashe County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34050	Avery County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34060	Beaufort County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34070	Bertie County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34080	Bladen County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34090	Brunswick County, N Carolina	9200	Urban	0.9237	0.9237	48900	Urban	0.9237
34100	Buncombe County, N Carolina	0480	Urban	0.9501	0.9191	11700	Urban	0.9346
34110	Burke County, N Carolina	3290	Urban	0.9502	0.9502	25860	Urban	0.9502
34120	Cabarrus County, N Carolina	1520	Urban	0.9711	0.9743	16740	Urban	0.9727
34130	Caldwell County, N Carolina	3290	Urban	0.9502	0.9502	25860	Urban	0.9502
34140	Camden County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34150	Carteret County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34160	Caswell County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34170	Catawba County, N Carolina	3290	Urban	0.9502	0.9502	25860	Urban	0.9502
34180	Chatham County, N Carolina	6640	Urban	1.0258	1.0363	20500	Urban	1.0311
34190	Cherokee County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34200	Chowan County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34210	Clay County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34220	Cleveland County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34230	Columbus County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34240	Craven County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34250	Cumberland County, N Carolina	2560	Urban	0.9363	0.9363	22180	Urban	0.9363
34251	Currituck County, N Carolina	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
34270	Dare County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
34280	Davidson County, N Carolina	3120	Urban	0.9312	0.8563	99934	Rural	0.8938
34290	Davie County, N Carolina	3120	Urban	0.9312	0.9401	49180	Urban	0.9357
34300	Duplin County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34310	Durham County, N Carolina	6640	Urban	1.0258	1.0363	20500	Urban	1.0311
34320	Edgecombe County, N Carolina	6895	Urban	0.8998	0.8998	40580	Urban	0.8998
34330	Forsyth County, N Carolina	3120	Urban	0.9312	0.9401	49180	Urban	0.9357
34340	Franklin County, N Carolina	6640	Urban	1.0258	1.0057	39580	Urban	1.0158
34350	Gaston County, N Carolina	1520	Urban	0.9711	0.9743	16740	Urban	0.9727
34360	Gates County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34370	Graham County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34380	Granville County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34390	Greene County, N Carolina	34	Rural	0.8500	0.9183	24780	Urban	0.8842
34400	Guilford County, N Carolina	3120	Urban	0.9312	0.9190	24660	Urban	0.9251
34410	Halifax County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34420	Harnett County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34430	Haywood County, N Carolina	34	Rural	0.8500	0.9191	11700	Urban	0.8846
34440	Henderson County, N Carolina	34	Rural	0.8500	0.9191	11700	Urban	0.8846
34450	Hertford County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34460	Hoke County, N Carolina	34	Rural	0.8500	0.9363	22180	Urban	0.8932
34470	Hyde County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34480	Iredell County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34490	Jackson County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34500	Johnston County, N Carolina	6640	Urban	1.0258	1.0057	39580	Urban	1.0158
34510	Jones County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34520	Lee County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34530	Lenoir County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34540	Lincoln County, N Carolina	1520	Urban	0.9711	0.8563	99934	Rural	0.9137
34550	Mc Dowell County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34560	Macon County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34570	Madison County, N Carolina	0480	Urban	0.9501	0.9191	11700	Urban	0.9346
34580	Martin County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34590	Mecklenburg County, N Carolina	1520	Urban	0.9711	0.9743	16740	Urban	0.9727
34600	Mitchell County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34610	Montgomery County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34620	Moore County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34630	Nash County, N Carolina	6895	Urban	0.8998	0.8998	40580	Urban	0.8998
34640	New Hanover County, N Carolina	9200	Urban	0.9237	0.9237	48900	Urban	0.9237
34650	Northampton County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34660	Onslow County, N Carolina	3605	Urban	0.8401	0.8401	27340	Urban	0.8401
34670	Orange County, N Carolina	6640	Urban	1.0258	1.0363	20500	Urban	1.0311
34680	Pamlico County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34690	Pasquotank County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34700	Pender County, N Carolina	34	Rural	0.8500	0.9237	48900	Urban	0.8869

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34710	Perquimans County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34720	Person County, N Carolina	34	Rural	0.8500	1.0363	20500	Urban	0.9432
34730	Pitt County, N Carolina	3150	Urban	0.9183	0.9183	24780	Urban	0.9183
34740	Polk County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34750	Randolph County, N Carolina	3120	Urban	0.9312	0.9190	24660	Urban	0.9251
34760	Richmond County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34770	Robeson County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34780	Rockingham County, N Carolina	34	Rural	0.8500	0.9190	24660	Urban	0.8845
34790	Rowan County, N Carolina	1520	Urban	0.9711	0.8563	99934	Rural	0.9137
34800	Rutherford County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34810	Sampson County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34820	Scotland County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34830	Stanly County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34840	Stokes County, N Carolina	3120	Urban	0.9312	0.9401	49180	Urban	0.9357
34850	Surry County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34860	Swain County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34870	Transylvania County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34880	Tyrrell County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34890	Union County, N Carolina	1520	Urban	0.9711	0.9743	16740	Urban	0.9727
34900	Vance County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34910	Wake County, N Carolina	6640	Urban	1.0258	1.0057	39580	Urban	1.0158
34920	Warren County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34930	Washington County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34940	Watauga County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34950	Wayne County, N Carolina	2980	Urban	0.8778	0.8778	24140	Urban	0.8778
34960	Wilkes County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34970	Wilson County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
34980	Yadkin County, N Carolina	3120	Urban	0.9312	0.9401	49180	Urban	0.9357
34981	Yancey County, N Carolina	34	Rural	0.8500	0.8563	99934	Rural	0.8532
35000	Adams County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35010	Barnes County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35020	Benson County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35030	Billings County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35040	Bottineau County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35050	Bowman County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35060	Burke County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35070	Burleigh County, N Dakota	1010	Urban	0.7505	0.7505	13900	Urban	0.7505
35080	Cass County, N Dakota	2520	Urban	0.9114	0.9114	22020	Urban	0.9114
35090	Cavalier County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35100	Dickey County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35110	Divide County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35120	Dunn County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35130	Eddy County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743

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35140	Emmons County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35150	Foster County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35160	Golden Valley County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35170	Grand Forks County, N Dakota	2985	Urban	0.9091	0.9091	24220	Urban	0.9091
35180	Grant County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35190	Griggs County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35200	Hettinger County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35210	Kidder County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35220	La Moure County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35230	Logan County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35240	Mc Henry County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35250	Mc Intosh County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35260	Mc Kenzie County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35270	Mc Lean County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35280	Mercer County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35290	Morton County, N Dakota	1010	Urban	0.7505	0.7505	13900	Urban	0.7505
35300	Mountrail County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35310	Nelson County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35320	Oliver County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35330	Pembina County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35340	Pierce County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35350	Ramsey County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35360	Ransom County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35370	Renville County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35380	Richland County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35390	Rolette County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35400	Sargent County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35410	Sheridan County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35420	Sioux County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35430	Slope County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35440	Stark County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35450	Steele County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35460	Stutsman County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35470	Towner County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35480	Traill County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35490	Walsh County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35500	Ward County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35510	Wells County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
35520	Williams County, N Dakota	35	Rural	0.7743	0.7743	99935	Rural	0.7743
36000	Adams County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36010	Allen County, Ohio	4320	Urban	0.9258	0.9330	30620	Urban	0.9294
36020	Ashland County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36030	Ashtabula County, Ohio	1680	Urban	0.9626	0.8693	99936	Rural	0.9160

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36040	Athens County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36050	Auglaize County, Ohio	4320	Urban	0.9258	0.8693	99936	Rural	0.8976
36060	Belmont County, Ohio	9000	Urban	0.7449	0.7449	48540	Urban	0.7449
36070	Brown County, Ohio	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
36080	Butler County, Ohio	3200	Urban	0.9066	0.9516	17140	Urban	0.9291
36090	Carroll County, Ohio	1320	Urban	0.8895	0.8895	15940	Urban	0.8895
36100	Champaign County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36110	Clark County, Ohio	2000	Urban	0.9231	0.8748	44220	Urban	0.8990
36120	Clermont County, Ohio	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
36130	Clinton County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36140	Columbiana County, Ohio	9320	Urban	0.9517	0.8693	99936	Rural	0.9105
36150	Coshocton County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36160	Crawford County, Ohio	4800	Urban	0.9105	0.8693	99936	Rural	0.8899
36170	Cuyahoga County, Ohio	1680	Urban	0.9626	0.9650	17460	Urban	0.9638
36190	Darke County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36200	Defiance County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36210	Delaware County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36220	Erie County, Ohio	36	Rural	0.8759	0.9017	41780	Urban	0.8888
36230	Fairfield County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36240	Fayette County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36250	Franklin County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36260	Fulton County, Ohio	8400	Urban	0.9524	0.9524	45780	Urban	0.9524
36270	Gallia County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36280	Geauga County, Ohio	1680	Urban	0.9626	0.9650	17460	Urban	0.9638
36290	Greene County, Ohio	2000	Urban	0.9231	0.9303	19380	Urban	0.9267
36300	Guernsey County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36310	Hamilton County, Ohio	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
36330	Hancock County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36340	Hardin County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36350	Harrison County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36360	Henry County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36370	Highland County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36380	Hocking County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36390	Holmes County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36400	Huron County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36410	Jackson County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36420	Jefferson County, Ohio	8080	Urban	0.8280	0.8280	48260	Urban	0.8280
36430	Knox County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36440	Lake County, Ohio	1680	Urban	0.9626	0.9650	17460	Urban	0.9638
36450	Lawrence County, Ohio	3400	Urban	0.9564	0.9564	26580	Urban	0.9564
36460	Licking County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36470	Logan County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36480	Lorain County, Ohio	1680	Urban	0.9626	0.9650	17460	Urban	0.9638

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
36490	Lucas County, Ohio	8400	Urban	0.9524	0.9524	45780	Urban	0.9524
36500	Madison County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36510	Mahoning County, Ohio	9320	Urban	0.9517	0.9237	49660	Urban	0.9377
36520	Marion County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36530	Medina County, Ohio	1680	Urban	0.9626	0.9650	17460	Urban	0.9638
36540	Meigs County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36550	Mercer County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36560	Miami County, Ohio	2000	Urban	0.9231	0.9303	19380	Urban	0.9267
36570	Monroe County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36580	Montgomery County, Ohio	2000	Urban	0.9231	0.9303	19380	Urban	0.9267
36590	Morgan County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36600	Morrow County, Ohio	36	Rural	0.8759	0.9737	18140	Urban	0.9248
36610	Muskingum County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36620	Noble County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36630	Ottawa County, Ohio	36	Rural	0.8759	0.9524	45780	Urban	0.9142
36640	Paulding County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36650	Perry County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36660	Pickaway County, Ohio	1840	Urban	0.9753	0.9737	18140	Urban	0.9745
36670	Pike County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36680	Portage County, Ohio	0080	Urban	0.9055	0.9055	10420	Urban	0.9055
36690	Preble County, Ohio	36	Rural	0.8759	0.9303	19380	Urban	0.9031
36700	Putnam County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36710	Richland County, Ohio	4800	Urban	0.9105	0.9189	31900	Urban	0.9147
36720	Ross County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36730	Sandusky County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36740	Scioto County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36750	Seneca County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36760	Shelby County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36770	Stark County, Ohio	1320	Urban	0.8895	0.8895	15940	Urban	0.8895
36780	Summit County, Ohio	0080	Urban	0.9055	0.9055	10420	Urban	0.9055
36790	Trumbull County, Ohio	9320	Urban	0.9517	0.9237	49660	Urban	0.9377
36800	Tuscarawas County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36810	Union County, Ohio	36	Rural	0.8759	0.9737	18140	Urban	0.9248
36820	Van Wert County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36830	Vinton County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36840	Warren County, Ohio	1640	Urban	0.9595	0.9516	17140	Urban	0.9556
36850	Washington County, Ohio	6020	Urban	0.8288	0.8288	37620	Urban	0.8288
36860	Wayne County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36870	Williams County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
36880	Wood County, Ohio	8400	Urban	0.9524	0.9524	45780	Urban	0.9524
36890	Wyandot County, Ohio	36	Rural	0.8759	0.8693	99936	Rural	0.8726
37000	Adair County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37010	Alfalfa County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612

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37020	Atoka County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37030	Beaver County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37040	Beckham County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37050	Blaine County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37060	Bryan County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37070	Caddo County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37080	Canadian County, Oklahoma	5880	Urban	0.8966	0.8982	36420	Urban	0.8974
37090	Carter County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37100	Cherokee County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37110	Choctaw County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37120	Cimarron County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37130	Cleveland County, Oklahoma	5880	Urban	0.8966	0.8982	36420	Urban	0.8974
37140	Coal County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37150	Comanche County, Oklahoma	4200	Urban	0.8212	0.8212	30020	Urban	0.8212
37160	Cotton County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37170	Craig County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37180	Creek County, Oklahoma	8560	Urban	0.8729	0.8690	46140	Urban	0.8710
37190	Custer County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37200	Delaware County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37210	Dewey County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37220	Ellis County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37230	Garfield County, Oklahoma	2340	Urban	0.9001	0.7686	99937	Rural	0.8344
37240	Garvin County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37250	Grady County, Oklahoma	37	Rural	0.7537	0.8982	36420	Urban	0.8260
37260	Grant County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37270	Greer County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37280	Harmon County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37290	Harper County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37300	Haskell County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37310	Hughes County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37320	Jackson County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37330	Jefferson County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37340	Johnston County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37350	Kay County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37360	Kingfisher County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37370	Kiowa County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37380	Latimer County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37390	Le Flore County, Oklahoma	37	Rural	0.7537	0.8283	22900	Urban	0.7910
37400	Lincoln County, Oklahoma	37	Rural	0.7537	0.8982	36420	Urban	0.8260
37410	Logan County, Oklahoma	5880	Urban	0.8966	0.8982	36420	Urban	0.8974
37420	Love County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37430	Mc Clain County, Oklahoma	5880	Urban	0.8966	0.8982	36420	Urban	0.8974
37440	Mc Curtain County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612

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37450	Mc Intosh County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37460	Major County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37470	Marshall County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37480	Mayes County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37490	Murray County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37500	Muskogee County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37510	Noble County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37520	Nowata County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37530	Okfuskee County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37540	Oklahoma County, Oklahoma	5880	Urban	0.8966	0.8982	36420	Urban	0.8974
37550	Okmulgee County, Oklahoma	37	Rural	0.7537	0.8690	46140	Urban	0.8114
37560	Osage County, Oklahoma	8560	Urban	0.8729	0.8690	46140	Urban	0.8710
37570	Ottawa County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37580	Pawnee County, Oklahoma	37	Rural	0.7537	0.8690	46140	Urban	0.8114
37590	Payne County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37600	Pittsburg County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37610	Pontotoc County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37620	Pottawatomie County, Oklahoma	5880	Urban	0.8966	0.7686	99937	Rural	0.8326
37630	Pushmataha County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37640	Roger Mills County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37650	Rogers County, Oklahoma	8560	Urban	0.8729	0.8690	46140	Urban	0.8710
37660	Seminole County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37670	Sequoyah County, Oklahoma	2720	Urban	0.8303	0.8283	22900	Urban	0.8293
37680	Stephens County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37690	Texas County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37700	Tillman County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37710	Tulsa County, Oklahoma	8560	Urban	0.8729	0.8690	46140	Urban	0.8710
37720	Wagoner County, Oklahoma	8560	Urban	0.8729	0.8690	46140	Urban	0.8710
37730	Washington County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37740	Washita County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37750	Woods County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
37760	Woodward County, Oklahoma	37	Rural	0.7537	0.7686	99937	Rural	0.7612
38000	Baker County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38010	Benton County, Oregon	1890	Urban	1.0545	1.0545	18700	Urban	1.0545
38020	Clackamas County, Oregon	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
38030	Clatsop County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38040	Columbia County, Oregon	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
38050	Coos County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38060	Crook County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38070	Curry County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38080	Deschutes County, Oregon	38	Rural	1.0049	1.0603	13460	Urban	1.0326
38090	Douglas County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38100	Gilliam County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982

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38110	Grant County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38120	Harney County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38130	Hood River County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38140	Jackson County, Oregon	4890	Urban	1.0534	1.0534	32780	Urban	1.0534
38150	Jefferson County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38160	Josephine County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38170	Klamath County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38180	Lake County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38190	Lane County, Oregon	2400	Urban	1.0940	1.0940	21660	Urban	1.0940
38200	Lincoln County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38210	Linn County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38220	Malheur County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38230	Marion County, Oregon	7080	Urban	1.0556	1.0556	41420	Urban	1.0556
38240	Morrow County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38250	Multnomah County, Oregon	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
38260	Polk County, Oregon	7080	Urban	1.0556	1.0556	41420	Urban	1.0556
38270	Sherman County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38280	Tillamook County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38290	Umatilla County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38300	Union County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38310	Wallowa County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38320	Wasco County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38330	Washington County, Oregon	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
38340	Wheeler County, Oregon	38	Rural	1.0049	0.9914	99938	Rural	0.9982
38350	Yamhill County, Oregon	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
39000	Adams County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39010	Allegheny County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39070	Armstrong County, Pennsylvania	39	Rural	0.8348	0.8736	38300	Urban	0.8542
39080	Beaver County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39100	Bedford County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39110	Berks County, Pennsylvania	6680	Urban	0.9215	0.9215	39740	Urban	0.9215
39120	Blair County, Pennsylvania	0280	Urban	0.8462	0.8462	11020	Urban	0.8462
39130	Bradford County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39140	Bucks County, Pennsylvania	6160	Urban	1.0824	1.0865	37964	Urban	1.0845
39150	Butler County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39160	Cambria County, Pennsylvania	3680	Urban	0.7980	0.8380	27780	Urban	0.8180
39180	Cameron County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39190	Carbon County, Pennsylvania	0240	Urban	0.9536	0.9501	10900	Urban	0.9519
39200	Centre County, Pennsylvania	8050	Urban	0.8461	0.8461	44300	Urban	0.8461
39210	Chester County, Pennsylvania	6160	Urban	1.0824	1.0865	37964	Urban	1.0845
39220	Clarion County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39230	Clearfield County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39240	Clinton County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329

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39250	Columbia County, Pennsylvania	7560	Urban	0.8522	0.8310	99939	Rural	0.8416
39260	Crawford County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39270	Cumberland County, Pennsylvania	3240	Urban	0.9286	0.9359	25420	Urban	0.9323
39280	Dauphin County, Pennsylvania	3240	Urban	0.9286	0.9359	25420	Urban	0.9323
39290	Delaware County, Pennsylvania	6160	Urban	1.0824	1.0865	37964	Urban	1.0845
39310	Elk County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39320	Erie County, Pennsylvania	2360	Urban	0.8699	0.8699	21500	Urban	0.8699
39330	Fayette County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39340	Forest County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39350	Franklin County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39360	Fulton County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39370	Greene County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39380	Huntingdon County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39390	Indiana County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39400	Jefferson County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39410	Juniata County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39420	Lackawanna County, Pennsylvania	7560	Urban	0.8522	0.8543	42540	Urban	0.8533
39440	Lancaster County, Pennsylvania	4000	Urban	0.9883	0.9883	29540	Urban	0.9883
39450	Lawrence County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39460	Lebanon County, Pennsylvania	3240	Urban	0.9286	0.8570	30140	Urban	0.8928
39470	Lehigh County, Pennsylvania	0240	Urban	0.9536	0.9501	10900	Urban	0.9519
39480	Luzerne County, Pennsylvania	7560	Urban	0.8522	0.8543	42540	Urban	0.8533
39510	Lycoming County, Pennsylvania	9140	Urban	0.8485	0.8485	48700	Urban	0.8485
39520	Mc Kean County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39530	Mercer County, Pennsylvania	7610	Urban	0.7881	0.9237	49660	Urban	0.8559
39540	Mifflin County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39550	Monroe County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39560	Montgomery County, Pennsylvania	6160	Urban	1.0824	1.0865	37964	Urban	1.0845
39580	Montour County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39590	Northampton County, Pennsylvania	0240	Urban	0.9536	0.9501	10900	Urban	0.9519
39600	Northumberland County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39610	Perry County, Pennsylvania	3240	Urban	0.9286	0.9359	25420	Urban	0.9323
39620	Philadelphia County, Pennsylvania	6160	Urban	1.0824	1.0865	37964	Urban	1.0845
39630	Pike County, Pennsylvania	5660	Urban	1.1170	1.1687	35084	Urban	1.1429
39640	Potter County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39650	Schuylkill County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39670	Snyder County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39680	Somerset County, Pennsylvania	3680	Urban	0.7980	0.8310	99939	Rural	0.8145
39690	Sullivan County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39700	Susquehanna County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39710	Tioga County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39720	Union County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39730	Venango County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
39740	Warren County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39750	Washington County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39760	Wayne County, Pennsylvania	39	Rural	0.8348	0.8310	99939	Rural	0.8329
39770	Westmoreland County, Pennsylvania	6280	Urban	0.8756	0.8736	38300	Urban	0.8746
39790	Wyoming County, Pennsylvania	7560	Urban	0.8522	0.8543	42540	Urban	0.8533
39800	York County, Pennsylvania	9280	Urban	0.9150	0.9150	49620	Urban	0.9150
40010	Adjuntas County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40020	Aguada County, Puerto Rico	0060	Urban	0.4294	0.4280	10380	Urban	0.4287
40030	Aguadilla County, Puerto Rico	0060	Urban	0.4294	0.4280	10380	Urban	0.4287
40040	Aguas Buenas County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40050	Aibonito County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40060	Anasco County, Puerto Rico	4840	Urban	0.4769	0.4280	10380	Urban	0.4525
40070	Arecibo County, Puerto Rico	0470	Urban	0.3757	0.4645	41980	Urban	0.4201
40080	Arroyo County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026
40090	Barceloneta County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40100	Barranquitas County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40110	Bayamon County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40120	Cabo Rojo County, Puerto Rico	4840	Urban	0.4769	0.5240	41900	Urban	0.5005
40130	Caguas County, Puerto Rico	1310	Urban	0.4061	0.4645	41980	Urban	0.4353
40140	Camuy County, Puerto Rico	0470	Urban	0.3757	0.4645	41980	Urban	0.4201
40145	Canovanas County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40150	Carolina County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40160	Catano County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40170	Cayey County, Puerto Rico	1310	Urban	0.4061	0.4645	41980	Urban	0.4353
40180	Ceiba County, Puerto Rico	7440	Urban	0.4802	0.3939	21940	Urban	0.4371
40190	Ciales County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40200	Cidra County, Puerto Rico	1310	Urban	0.4061	0.4645	41980	Urban	0.4353
40210	Coamo County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40220	Comerio County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40230	Corozal County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40240	Culebra County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40250	Dorado County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40260	Fajardo County, Puerto Rico	7440	Urban	0.4802	0.3939	21940	Urban	0.4371
40265	Florida County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40270	Guanica County, Puerto Rico	40	Rural	0.4047	0.4493	49500	Urban	0.4270
40280	Guayama County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026
40290	Guayanilla County, Puerto Rico	6360	Urban	0.4954	0.4493	49500	Urban	0.4724
40300	Guaynabo County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40310	Gurabo County, Puerto Rico	1310	Urban	0.4061	0.4645	41980	Urban	0.4353
40320	Hatillo County, Puerto Rico	0470	Urban	0.3757	0.4645	41980	Urban	0.4201
40330	Hormigueros County, Puerto Rico	4840	Urban	0.4769	0.4493	32420	Urban	0.4631
40340	Humacao County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40350	Isabela County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164

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40360	Jayuya County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40370	Juana Diaz County, Puerto Rico	6360	Urban	0.4954	0.5006	38660	Urban	0.4980
40380	Juncos County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40390	Lajas County, Puerto Rico	40	Rural	0.4047	0.5240	41900	Urban	0.4644
40400	Lares County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40410	Las Marias County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40420	Las Piedras County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40430	Loiza County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40440	Luquillo County, Puerto Rico	7440	Urban	0.4802	0.3939	21940	Urban	0.4371
40450	Manati County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40460	Maricao County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40470	Maunabo County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40480	Mayaguez County, Puerto Rico	4840	Urban	0.4769	0.4493	32420	Urban	0.4631
40490	Moca County, Puerto Rico	0060	Urban	0.4294	0.4280	10380	Urban	0.4287
40500	Morovis County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40510	Naguabo County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40520	Naranjito County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40530	Orocovis County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40540	Patillas County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026
40550	Penuelas County, Puerto Rico	6360	Urban	0.4954	0.4493	49500	Urban	0.4724
40560	Ponce County, Puerto Rico	6360	Urban	0.4954	0.5006	38660	Urban	0.4980
40570	Quebradillas County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40580	Rincon County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40590	Rio Grande County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40610	Sabana Grande County, Puerto Rico	4840	Urban	0.4769	0.5240	41900	Urban	0.5005
40620	Salinas County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40630	San German County, Puerto Rico	4840	Urban	0.4769	0.5240	41900	Urban	0.5005
40640	San Juan County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40650	San Lorenzo County, Puerto Rico	1310	Urban	0.4061	0.4645	41980	Urban	0.4353
40660	San Sebastian County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40670	Santa Isabel County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40680	Toa Alta County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40690	Toa Baja County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40700	Trujillo Alto County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40710	Utuado County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40720	Vega Alta County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40730	Vega Baja County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40740	Vieques County, Puerto Rico	40	Rural	0.4047	0.4047	99940	Rural	0.4047
40750	Villalba County, Puerto Rico	6360	Urban	0.4954	0.5006	38660	Urban	0.4980
40760	Yabucoa County, Puerto Rico	7440	Urban	0.4802	0.4645	41980	Urban	0.4724
40770	Yauco County, Puerto Rico	6360	Urban	0.4954	0.4493	49500	Urban	0.4724
41000	Bristol County, Rhode Island	6483	Urban	1.1061	1.0929	39300	Urban	1.0995
41010	Kent County, Rhode Island	6483	Urban	1.1061	1.0929	39300	Urban	1.0995

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41020	Newport County, Rhode Island	6483	Urban	1.1061	1.0929	39300	Urban	1.0995
41030	Providence County, Rhode Island	6483	Urban	1.1061	1.0929	39300	Urban	1.0995
41050	Washington County, Rhode Island	6483	Urban	1.1061	1.0929	39300	Urban	1.0995
42000	Abbeville County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42010	Aiken County, S Carolina	0600	Urban	0.9208	0.9154	12260	Urban	0.9181
42020	Allendale County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42030	Anderson County, S Carolina	3160	Urban	0.9400	0.8670	11340	Urban	0.9035
42040	Bamberg County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42050	Barnwell County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42060	Beaufort County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42070	Berkeley County, S Carolina	1440	Urban	0.9420	0.9420	16700	Urban	0.9420
42080	Calhoun County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42090	Charleston County, S Carolina	1440	Urban	0.9420	0.9420	16700	Urban	0.9420
42100	Cherokee County, S Carolina	3160	Urban	0.9400	0.8683	99942	Rural	0.9042
42110	Chester County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42120	Chesterfield County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42130	Clarendon County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42140	Colleton County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42150	Darlington County, S Carolina	42	Rural	0.8640	0.8833	22500	Urban	0.8737
42160	Dillon County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42170	Dorchester County, S Carolina	1440	Urban	0.9420	0.9420	16700	Urban	0.9420
42180	Edgefield County, S Carolina	0600	Urban	0.9208	0.9154	12260	Urban	0.9181
42190	Fairfield County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42200	Florence County, S Carolina	2655	Urban	0.8960	0.8833	22500	Urban	0.8897
42210	Georgetown County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42220	Greenville County, S Carolina	3160	Urban	0.9400	0.9557	24860	Urban	0.9479
42230	Greenwood County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42240	Hampton County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42250	Horry County, S Carolina	5330	Urban	0.9022	0.9022	34820	Urban	0.9022
42260	Jasper County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42270	Kershaw County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42280	Lancaster County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42290	Laurens County, S Carolina	42	Rural	0.8640	0.9557	24860	Urban	0.9099
42300	Lee County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42310	Lexington County, S Carolina	1760	Urban	0.9450	0.9392	17900	Urban	0.9421
42320	Mc Cormick County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42330	Marion County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42340	Marlboro County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42350	Newberry County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42360	Oconee County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42370	Orangeburg County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42380	Pickens County, S Carolina	3160	Urban	0.9400	0.9557	24860	Urban	0.9479
42390	Richland County, S Carolina	1760	Urban	0.9450	0.9392	17900	Urban	0.9421

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42400	Saluda County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42410	Spartanburg County, S Carolina	3160	Urban	0.9400	0.9519	43900	Urban	0.9460
42420	Sumter County, S Carolina	8140	Urban	0.8520	0.8520	44940	Urban	0.8520
42430	Union County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42440	Williamsburg County, S Carolina	42	Rural	0.8640	0.8683	99942	Rural	0.8662
42450	York County, S Carolina	1520	Urban	0.9711	0.9743	16740	Urban	0.9727
43010	Aurora County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43020	Beadle County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43030	Bennett County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43040	Bon Homme County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43050	Brookings County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43060	Brown County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43070	Brule County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43080	Buffalo County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43090	Butte County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43100	Campbell County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43110	Charles Mix County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43120	Clark County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43130	Clay County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43140	Codington County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43150	Corson County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43160	Custer County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43170	Davison County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43180	Day County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43190	Deuel County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43200	Dewey County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43210	Douglas County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43220	Edmunds County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43230	Fall River County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43240	Faulk County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43250	Grant County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43260	Gregory County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43270	Haakon County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43280	Hamlin County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43290	Hand County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43300	Hanson County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43310	Harding County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43320	Hughes County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43330	Hutchinson County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43340	Hyde County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43350	Jackson County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43360	Jerauld County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43370	Jones County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
43380	Kingsbury County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43390	Lake County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43400	Lawrence County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43410	Lincoln County, S Dakota	7760	Urban	0.9441	0.9441	43620	Urban	0.9441
43420	Lyman County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43430	Mc Cook County, S Dakota	43	Rural	0.8393	0.9441	43620	Urban	0.8917
43440	Mc Pherson County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43450	Marshall County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43460	Meade County, S Dakota	43	Rural	0.8393	0.8912	39660	Urban	0.8653
43470	Mellette County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43480	Miner County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43490	Minnehaha County, S Dakota	7760	Urban	0.9441	0.9441	43620	Urban	0.9441
43500	Moody County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43510	Pennington County, S Dakota	6660	Urban	0.8912	0.8912	39660	Urban	0.8912
43520	Perkins County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43530	Potter County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43540	Roberts County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43550	Sanborn County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43560	Shannon County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43570	Spink County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43580	Stanley County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43590	Sully County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43600	Todd County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43610	Tripp County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43620	Turner County, S Dakota	43	Rural	0.8393	0.9441	43620	Urban	0.8917
43630	Union County, S Dakota	43	Rural	0.8393	0.9070	43580	Urban	0.8732
43640	Walworth County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43650	Washabaugh County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43670	Yankton County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
43680	Ziebach County, S Dakota	43	Rural	0.8393	0.8398	99943	Rural	0.8396
44000	Anderson County, Tennessee	3840	Urban	0.8508	0.8548	28940	Urban	0.8528
44010	Bedford County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44020	Benton County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44030	Bledsoe County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44040	Blount County, Tennessee	3840	Urban	0.8508	0.8548	28940	Urban	0.8528
44050	Bradley County, Tennessee	44	Rural	0.7876	0.7844	17420	Urban	0.7860
44060	Campbell County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44070	Cannon County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44080	Carroll County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44090	Carter County, Tennessee	3660	Urban	0.8202	0.8146	27740	Urban	0.8174
44100	Cheatham County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44110	Chester County, Tennessee	3580	Urban	0.8900	0.8900	27180	Urban	0.8900
44120	Claiborne County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
44130	Clay County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44140	Cocke County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44150	Coffee County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44160	Crockett County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44170	Cumberland County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44180	Davidson County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44190	Decatur County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44200	De Kalb County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44210	Dickson County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44220	Dyer County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44230	Fayette County, Tennessee	4920	Urban	0.9234	0.9217	32820	Urban	0.9226
44240	Fentress County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44250	Franklin County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44260	Gibson County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44270	Giles County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44280	Grainger County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44290	Greene County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44300	Grundy County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44310	Hamblen County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44320	Hamilton County, Tennessee	1560	Urban	0.9207	0.9207	16860	Urban	0.9207
44330	Hancock County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44340	Hardeman County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44350	Hardin County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44360	Hawkins County, Tennessee	3660	Urban	0.8202	0.8240	28700	Urban	0.8221
44370	Haywood County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44380	Henderson County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44390	Henry County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44400	Hickman County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44410	Houston County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44420	Humphreys County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44430	Jackson County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44440	Jefferson County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44450	Johnson County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44460	Knox County, Tennessee	3840	Urban	0.8508	0.8548	28940	Urban	0.8528
44470	Lake County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44480	Lauderdale County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44490	Lawrence County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44500	Lewis County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44510	Lincoln County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44520	Loudon County, Tennessee	3840	Urban	0.8508	0.8548	28940	Urban	0.8528
44530	Mc Minn County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44540	Mc Nairy County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44550	Macon County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981

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44560	Madison County, Tennessee	3580	Urban	0.8900	0.8900	27180	Urban	0.8900
44570	Marion County, Tennessee	1560	Urban	0.9207	0.9207	16860	Urban	0.9207
44580	Marshall County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44590	Maury County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44600	Meigs County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44610	Monroe County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44620	Montgomery County, Tennessee	1660	Urban	0.8022	0.8022	17300	Urban	0.8022
44630	Moore County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44640	Morgan County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44650	Obion County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44660	Overton County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44670	Perry County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44680	Pickett County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44690	Polk County, Tennessee	44	Rural	0.7876	0.7844	17420	Urban	0.7860
44700	Putnam County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44710	Rhea County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44720	Roane County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44730	Robertson County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44740	Rutherford County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44750	Scott County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44760	Sequatchie County, Tennessee	44	Rural	0.7876	0.9207	16860	Urban	0.8542
44770	Sevier County, Tennessee	3840	Urban	0.8508	0.7869	99944	Rural	0.8189
44780	Shelby County, Tennessee	4920	Urban	0.9234	0.9217	32820	Urban	0.9226
44790	Smith County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44800	Stewart County, Tennessee	44	Rural	0.7876	0.8022	17300	Urban	0.7949
44810	Sullivan County, Tennessee	3660	Urban	0.8202	0.8240	28700	Urban	0.8221
44820	Sumner County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44830	Tipton County, Tennessee	4920	Urban	0.9234	0.9217	32820	Urban	0.9226
44840	Trousdale County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44850	Unicoi County, Tennessee	3660	Urban	0.8202	0.8146	27740	Urban	0.8174
44860	Union County, Tennessee	3840	Urban	0.8508	0.8548	28940	Urban	0.8528
44870	Van Buren County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44880	Warren County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44890	Washington County, Tennessee	3660	Urban	0.8202	0.8146	27740	Urban	0.8174
44900	Wayne County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44910	Weakley County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44920	White County, Tennessee	44	Rural	0.7876	0.7869	99944	Rural	0.7873
44930	Williamson County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
44940	Wilson County, Tennessee	5360	Urban	1.0108	1.0086	34980	Urban	1.0097
45000	Anderson County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45010	Andrews County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45020	Angelina County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45030	Aransas County, Texas	45	Rural	0.7910	0.8647	18580	Urban	0.8279

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45040	Archer County, Texas	9080	Urban	0.8395	0.8332	48660	Urban	0.8364
45050	Armstrong County, Texas	45	Rural	0.7910	0.9178	11100	Urban	0.8544
45060	Atascosa County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45070	Austin County, Texas	45	Rural	0.7910	0.9973	26420	Urban	0.8942
45080	Bailey County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45090	Bandera County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45100	Bastrop County, Texas	0640	Urban	0.9595	0.9595	12420	Urban	0.9595
45110	Baylor County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45113	Bee County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45120	Bell County, Texas	3810	Urban	0.9242	0.9242	28660	Urban	0.9242
45130	Bexar County, Texas	7240	Urban	0.9023	0.9003	41700	Urban	0.9013
45140	Blanco County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45150	Borden County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45160	Bosque County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45170	Bowie County, Texas	8360	Urban	0.8413	0.8413	45500	Urban	0.8413
45180	Brazoria County, Texas	1145	Urban	0.8524	0.9973	26420	Urban	0.9249
45190	Brazos County, Texas	1260	Urban	0.9243	0.9243	17780	Urban	0.9243
45200	Brewster County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45201	Briscoe County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45210	Brooks County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45220	Brown County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45221	Burleson County, Texas	45	Rural	0.7910	0.9243	17780	Urban	0.8577
45222	Burnet County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45223	Caldwell County, Texas	0640	Urban	0.9595	0.9595	12420	Urban	0.9595
45224	Calhoun County, Texas	45	Rural	0.7910	0.8470	47020	Urban	0.8190
45230	Callahan County, Texas	45	Rural	0.7910	0.7850	10180	Urban	0.7880
45240	Cameron County, Texas	1240	Urban	1.0125	1.0125	15180	Urban	1.0125
45250	Camp County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45251	Carson County, Texas	45	Rural	0.7910	0.9178	11100	Urban	0.8544
45260	Cass County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45270	Castro County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45280	Chambers County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45281	Cherokee County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45290	Childress County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45291	Clay County, Texas	45	Rural	0.7910	0.8332	48660	Urban	0.8121
45292	Cochran County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45300	Coke County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45301	Coleman County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45310	Collin County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45311	Collingsworth County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45312	Colorado County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45320	Comal County, Texas	7240	Urban	0.9023	0.9003	41700	Urban	0.9013
45321	Comanche County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938

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45330	Concho County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45340	Cooke County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45341	Coryell County, Texas	3810	Urban	0.9242	0.9242	28660	Urban	0.9242
45350	Cottle County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45360	Crane County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45361	Crockett County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45362	Crosby County, Texas	45	Rural	0.7910	0.8777	31180	Urban	0.8344
45370	Culberson County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45380	Dallam County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45390	Dallas County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45391	Dawson County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45392	Deaf Smith County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45400	Delta County, Texas	45	Rural	0.7910	1.0074	19124	Urban	0.8992
45410	Denton County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45420	De Witt County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45421	Dickens County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45430	Dimmit County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45431	Donley County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45440	Duval County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45450	Eastland County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45451	Ector County, Texas	5800	Urban	0.9632	0.9798	36220	Urban	0.9715
45460	Edwards County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45470	Ellis County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45480	El Paso County, Texas	2320	Urban	0.9181	0.9181	21340	Urban	0.9181
45490	Erath County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45500	Falls County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45510	Fannin County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45511	Fayette County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45520	Fisher County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45521	Floyd County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45522	Foard County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45530	Fort Bend County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45531	Franklin County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45540	Freestone County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45541	Frio County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45542	Gaines County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45550	Galveston County, Texas	2920	Urban	0.9403	0.9973	26420	Urban	0.9688
45551	Garza County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45552	Gillespie County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45560	Glasscock County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45561	Goliad County, Texas	45	Rural	0.7910	0.8470	47020	Urban	0.8190
45562	Gonzales County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45563	Gray County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
45564	Grayson County, Texas	7640	Urban	0.9617	0.9617	43300	Urban	0.9617
45570	Gregg County, Texas	4420	Urban	0.8739	0.8801	30980	Urban	0.8770
45580	Grimes County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45581	Guadalupe County, Texas	7240	Urban	0.9023	0.9003	41700	Urban	0.9013
45582	Hale County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45583	Hall County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45590	Hamilton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45591	Hansford County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45592	Hardeman County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45600	Hardin County, Texas	0840	Urban	0.8616	0.8616	13140	Urban	0.8616
45610	Harris County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45620	Harrison County, Texas	4420	Urban	0.8739	0.7966	99945	Rural	0.8353
45621	Hartley County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45630	Haskell County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45631	Hays County, Texas	0640	Urban	0.9595	0.9595	12420	Urban	0.9595
45632	Hemphill County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45640	Henderson County, Texas	1920	Urban	1.0054	0.7966	99945	Rural	0.9010
45650	Hidalgo County, Texas	4880	Urban	0.8602	0.8602	32580	Urban	0.8602
45651	Hill County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45652	Hockley County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45653	Hood County, Texas	2800	Urban	0.9520	0.7966	99945	Rural	0.8743
45654	Hopkins County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45660	Houston County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45661	Howard County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45662	Hudspeth County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45670	Hunt County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45671	Hutchinson County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45672	Irion County, Texas	45	Rural	0.7910	0.8167	41660	Urban	0.8039
45680	Jack County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45681	Jackson County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45690	Jasper County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45691	Jeff Davis County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45700	Jefferson County, Texas	0840	Urban	0.8616	0.8616	13140	Urban	0.8616
45710	Jim Hogg County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45711	Jim Wells County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45720	Johnson County, Texas	2800	Urban	0.9520	0.9472	23104	Urban	0.9496
45721	Jones County, Texas	45	Rural	0.7910	0.7850	10180	Urban	0.7880
45722	Karnes County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45730	Kaufman County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45731	Kendall County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45732	Kenedy County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45733	Kent County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45734	Kerr County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
45740	Kimble County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45741	King County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45742	Kinney County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45743	Kleberg County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45744	Knox County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45750	Lamar County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45751	Lamb County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45752	Lampasas County, Texas	45	Rural	0.7910	0.9242	28660	Urban	0.8576
45753	La Salle County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45754	Lavaca County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45755	Lee County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45756	Leon County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45757	Liberty County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45758	Limestone County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45759	Lipscomb County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45760	Live Oak County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45761	Llano County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45762	Loving County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45770	Lubbock County, Texas	4600	Urban	0.8777	0.8777	31180	Urban	0.8777
45771	Lynn County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45772	Mc Culloch County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45780	Mc Lennan County, Texas	8800	Urban	0.8146	0.8146	47380	Urban	0.8146
45781	Mc Mullen County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45782	Madison County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45783	Marion County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45784	Martin County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45785	Mason County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45790	Matagorda County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45791	Maverick County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45792	Medina County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45793	Menard County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45794	Midland County, Texas	5800	Urban	0.9632	0.9384	33260	Urban	0.9508
45795	Milam County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45796	Mills County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45797	Mitchell County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45800	Montague County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45801	Montgomery County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45802	Moore County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45803	Morris County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45804	Motley County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45810	Nacogdoches County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45820	Navarro County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45821	Newton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938

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45822	Nolan County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45830	Nueces County, Texas	1880	Urban	0.8647	0.8647	18580	Urban	0.8647
45831	Ochiltree County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45832	Oldham County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45840	Orange County, Texas	0840	Urban	0.8616	0.8616	13140	Urban	0.8616
45841	Palo Pinto County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45842	Panola County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45843	Parker County, Texas	2800	Urban	0.9520	0.9472	23104	Urban	0.9496
45844	Parmer County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45845	Pecos County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45850	Polk County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45860	Potter County, Texas	0320	Urban	0.9178	0.9178	11100	Urban	0.9178
45861	Presidio County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45870	Rains County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45871	Randall County, Texas	0320	Urban	0.9178	0.9178	11100	Urban	0.9178
45872	Reagan County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45873	Real County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45874	Red River County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45875	Reeves County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45876	Refugio County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45877	Roberts County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45878	Robertson County, Texas	45	Rural	0.7910	0.9243	17780	Urban	0.8577
45879	Rockwall County, Texas	1920	Urban	1.0054	1.0074	19124	Urban	1.0064
45880	Runnels County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45881	Rusk County, Texas	45	Rural	0.7910	0.8801	30980	Urban	0.8356
45882	Sabine County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45883	San Augustine County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45884	San Jacinto County, Texas	45	Rural	0.7910	0.9973	26420	Urban	0.8942
45885	San Patricio County, Texas	1880	Urban	0.8647	0.8647	18580	Urban	0.8647
45886	San Saba County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45887	Schleicher County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45888	Scurry County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45889	Shackelford County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45890	Shelby County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45891	Sherman County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45892	Smith County, Texas	8640	Urban	0.9502	0.9502	46340	Urban	0.9502
45893	Somervell County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45900	Starr County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45901	Stephens County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45902	Sterling County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45903	Stonewall County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45904	Sutton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45905	Swisher County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938

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45910	Tarrant County, Texas	2800	Urban	0.9520	0.9472	23104	Urban	0.9496
45911	Taylor County, Texas	0040	Urban	0.8009	0.7850	10180	Urban	0.7930
45912	Terrell County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45913	Terry County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45920	Throckmorton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45921	Titus County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45930	Tom Green County, Texas	7200	Urban	0.8167	0.8167	41660	Urban	0.8167
45940	Travis County, Texas	0640	Urban	0.9595	0.9595	12420	Urban	0.9595
45941	Trinity County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45942	Tyler County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45943	Upshur County, Texas	4420	Urban	0.8739	0.8801	30980	Urban	0.8770
45944	Upton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45945	Uvalde County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45946	Val Verde County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45947	Van Zandt County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45948	Victoria County, Texas	8750	Urban	0.8469	0.8470	47020	Urban	0.8470
45949	Walker County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45950	Waller County, Texas	3360	Urban	1.0117	0.9973	26420	Urban	1.0045
45951	Ward County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45952	Washington County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45953	Webb County, Texas	4080	Urban	0.8747	0.8747	29700	Urban	0.8747
45954	Wharton County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45955	Wheeler County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45960	Wichita County, Texas	9080	Urban	0.8395	0.8332	48660	Urban	0.8364
45961	Wilbarger County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45962	Willacy County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45970	Williamson County, Texas	0640	Urban	0.9595	0.9595	12420	Urban	0.9595
45971	Wilson County, Texas	7240	Urban	0.9023	0.9003	41700	Urban	0.9013
45972	Winkler County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45973	Wise County, Texas	45	Rural	0.7910	0.9472	23104	Urban	0.8691
45974	Wood County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45980	Yoakum County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45981	Young County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45982	Zapata County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
45983	Zavala County, Texas	45	Rural	0.7910	0.7966	99945	Rural	0.7938
46000	Beaver County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46010	Box Elder County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46020	Cache County, Utah	46	Rural	0.8843	0.9094	30860	Urban	0.8969
46030	Carbon County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46040	Daggett County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46050	Davis County, Utah	7160	Urban	0.9487	0.9216	36260	Urban	0.9352
46060	Duchesne County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46070	Emery County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565

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46080	Garfield County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46090	Grand County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46100	Iron County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46110	Juab County, Utah	46	Rural	0.8843	0.9588	39340	Urban	0.9216
46120	Kane County, Utah	2620	Urban	1.0611	0.8287	99946	Rural	0.9449
46130	Millard County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46140	Morgan County, Utah	46	Rural	0.8843	0.9216	36260	Urban	0.9030
46150	Piute County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46160	Rich County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46170	Salt Lake County, Utah	7160	Urban	0.9487	0.9561	41620	Urban	0.9524
46180	San Juan County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46190	Sanpete County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46200	Sevier County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46210	Summit County, Utah	46	Rural	0.8843	0.9561	41620	Urban	0.9202
46220	Tooele County, Utah	46	Rural	0.8843	0.9561	41620	Urban	0.9202
46230	Uintah County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46240	Utah County, Utah	6520	Urban	0.9613	0.9588	39340	Urban	0.9601
46250	Wasatch County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46260	Washington County, Utah	46	Rural	0.8843	0.9458	41100	Urban	0.9151
46270	Wayne County, Utah	46	Rural	0.8843	0.8287	99946	Rural	0.8565
46280	Weber County, Utah	7160	Urban	0.9487	0.9216	36260	Urban	0.9352
47000	Addison County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47010	Bennington County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47020	Caledonia County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47030	Chittenden County, Vermont	1303	Urban	0.9322	0.9322	15540	Urban	0.9322
47040	Essex County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47050	Franklin County, Vermont	1303	Urban	0.9322	0.9322	15540	Urban	0.9322
47060	Grand Isle County, Vermont	1303	Urban	0.9322	0.9322	15540	Urban	0.9322
47070	Lamoille County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47080	Orange County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47090	Orleans County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47100	Rutland County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47110	Washington County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47120	Windham County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
47130	Windsor County, Vermont	47	Rural	0.9375	0.9375	99947	Rural	0.9375
48010	St Croix County, Virgin Islands	48	Rural	0.7456	0.7456	99948	Rural	0.7456
48020	St Thomas-John County, Virgin Islands	48	Rural	0.7456	0.7456	99948	Rural	0.7456
49000	Accomack County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49010	Albemarle County, Virginia	1540	Urban	1.0294	1.0294	16820	Urban	1.0294
49011	Alexandria City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49020	Alleghany County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49030	Amelia County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49040	Amherst County, Virginia	4640	Urban	0.9017	0.9017	31340	Urban	0.9017

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
49050	Appomattox County, Virginia	49	Rural	0.8479	0.9017	31340	Urban	0.8748
49060	Arlington County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49070	Augusta County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49080	Bath County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49088	Bedford City County, Virginia	4640	Urban	0.9017	0.9017	31340	Urban	0.9017
49090	Bedford County, Virginia	4640	Urban	0.9017	0.9017	31340	Urban	0.9017
49100	Bland County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49110	Botetourt County, Virginia	6800	Urban	0.8428	0.8415	40220	Urban	0.8422
49111	Bristol City County, Virginia	3660	Urban	0.8202	0.8240	28700	Urban	0.8221
49120	Brunswick County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49130	Buchanan County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49140	Buckingham County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49141	Buena Vista City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49150	Campbell County, Virginia	4640	Urban	0.9017	0.9017	31340	Urban	0.9017
49160	Caroline County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49170	Carroll County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49180	Charles City County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49190	Charlotte County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49191	Charlottesville City County, Virginia	1540	Urban	1.0294	1.0294	16820	Urban	1.0294
49194	Chesapeake County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49200	Chesterfield County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49210	Clarke County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49211	Clifton Forge City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49212	Colonial Heights County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49213	Covington City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49220	Craig County, Virginia	49	Rural	0.8479	0.8415	40220	Urban	0.8447
49230	Culpeper County, Virginia	8840	Urban	1.0971	0.8049	99949	Rural	0.9510
49240	Cumberland County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49241	Danville City County, Virginia	1950	Urban	0.8643	0.8643	19260	Urban	0.8643
49250	Dickenson County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49260	Dinniddie County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49270	Emporia County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49280	Essex County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49288	Fairfax City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49290	Fairfax County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49291	Falls Church City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49300	Fauquier County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49310	Floyd County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49320	Fluvanna County, Virginia	1540	Urban	1.0294	1.0294	16820	Urban	1.0294
49328	Franklin City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49330	Franklin County, Virginia	49	Rural	0.8479	0.8415	40220	Urban	0.8447
49340	Frederick County, Virginia	49	Rural	0.8479	1.0496	49020	Urban	0.9488

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
49342	Fredericksburg City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49343	Galax City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49350	Giles County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49360	Gloucester County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49370	Goochland County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49380	Grayson County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49390	Greene County, Virginia	1540	Urban	1.0294	1.0294	16820	Urban	1.0294
49400	Greensville County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49410	Halifax County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49411	Hampton City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49420	Hanover County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49421	Harrisonburg City County, Virginia	49	Rural	0.8479	0.9275	25500	Urban	0.8877
49430	Henrico County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49440	Henry County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49450	Highland County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49451	Hopewell City County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49460	Isle Of Wight County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49470	James City Co County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49480	King And Queen County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49490	King George County, Virginia	8840	Urban	1.0971	0.8049	99949	Rural	0.9510
49500	King William County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49510	Lancaster County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49520	Lee County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49522	Lexington County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49530	Loudoun County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49540	Louisa County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49550	Lunenburg County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49551	Lynchburg City County, Virginia	4640	Urban	0.9017	0.9017	31340	Urban	0.9017
49560	Madison County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49561	Martinsville City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49563	Manassas City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49565	Manassas Park City County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49570	Mathews County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49580	Mecklenburg County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49590	Middlesex County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49600	Montgomery County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49610	Nansemond, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49620	Nelson County, Virginia	49	Rural	0.8479	1.0294	16820	Urban	0.9387
49621	New Kent County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49622	Newport News City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49641	Norfolk City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49650	Northampton County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264

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49660	Northumberland County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49661	Norton City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49670	Nottoway County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49680	Orange County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49690	Page County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49700	Patrick County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49701	Petersburg City County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49710	Pittsylvania County, Virginia	1950	Urban	0.8643	0.8643	19260	Urban	0.8643
49711	Portsmouth City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49712	Poquoson City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49720	Powhatan County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49730	Prince Edward County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49740	Prince George County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49750	Prince William County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49770	Pulaski County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49771	Radford City County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49780	Rappahannock County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49790	Richmond County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49791	Richmond City County, Virginia	6760	Urban	0.9397	0.9397	40060	Urban	0.9397
49800	Roanoke County, Virginia	6800	Urban	0.8428	0.8415	40220	Urban	0.8422
49801	Roanoke City County, Virginia	6800	Urban	0.8428	0.8415	40220	Urban	0.8422
49810	Rockbridge County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49820	Rockingham County, Virginia	49	Rural	0.8479	0.9275	25500	Urban	0.8877
49830	Russell County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49838	Salem County, Virginia	6800	Urban	0.8428	0.8415	40220	Urban	0.8422
49840	Scott County, Virginia	3660	Urban	0.8202	0.8240	28700	Urban	0.8221
49850	Shenandoah County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49860	Smyth County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49867	South Boston City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49870	Southampton County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49880	Spotsylvania County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49890	Stafford County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49891	Staunton City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49892	Suffolk City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49900	Surry County, Virginia	49	Rural	0.8479	0.8894	47260	Urban	0.8687
49910	Sussex County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49920	Tazewell County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49921	Virginia Beach City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
49930	Warren County, Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
49950	Washington County, Virginia	3660	Urban	0.8202	0.8240	28700	Urban	0.8221
49951	Waynesboro City County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49960	Westmoreland County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49961	Williamsburg City County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894

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49962	Winchester City County, Virginia	49	Rural	0.8479	1.0496	49020	Urban	0.9488
49970	Wise County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49980	Wythe County, Virginia	49	Rural	0.8479	0.8049	99949	Rural	0.8264
49981	York County, Virginia	5720	Urban	0.8894	0.8894	47260	Urban	0.8894
50000	Adams County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50010	Asotin County, Washington	50	Rural	1.0072	0.9314	30300	Urban	0.9693
50020	Benton County, Washington	6740	Urban	1.0520	1.0520	28420	Urban	1.0520
50030	Chelan County, Washington	50	Rural	1.0072	0.9427	48300	Urban	0.9750
50040	Clallam County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50050	Clark County, Washington	6440	Urban	1.1403	1.1403	38900	Urban	1.1403
50060	Columbia County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50070	Cowlitz County, Washington	50	Rural	1.0072	1.0224	31020	Urban	1.0148
50080	Douglas County, Washington	50	Rural	1.0072	0.9427	48300	Urban	0.9750
50090	Ferry County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50100	Franklin County, Washington	6740	Urban	1.0520	1.0520	28420	Urban	1.0520
50110	Garfield County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50120	Grant County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50130	Grays Harbor County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50140	Island County, Washington	7600	Urban	1.1479	1.0312	99950	Rural	1.0896
50150	Jefferson County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50160	King County, Washington	7600	Urban	1.1479	1.1492	42644	Urban	1.1486
50170	Kitsap County, Washington	1150	Urban	1.0614	1.0614	14740	Urban	1.0614
50180	Kittitas County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50190	Klickitat County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50200	Lewis County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50210	Lincoln County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50220	Mason County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50230	Okanogan County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50240	Pacific County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50250	Pend Oreille County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50260	Pierce County, Washington	8200	Urban	1.1078	1.1078	45104	Urban	1.1078
50270	San Juan County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50280	Skagit County, Washington	50	Rural	1.0072	1.0576	34580	Urban	1.0324
50290	Skamania County, Washington	50	Rural	1.0072	1.1403	38900	Urban	1.0738
50300	Snohomish County, Washington	7600	Urban	1.1479	1.1492	42644	Urban	1.1486
50310	Spokane County, Washington	7840	Urban	1.0660	1.0660	44060	Urban	1.0660
50320	Stevens County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50330	Thurston County, Washington	5910	Urban	1.1006	1.1006	36500	Urban	1.1006
50340	Wahkiakum County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50350	Walla Walla County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50360	Whatcom County, Washington	0860	Urban	1.1642	1.1642	13380	Urban	1.1642
50370	Whitman County, Washington	50	Rural	1.0072	1.0312	99950	Rural	1.0192
50380	Yakima County, Washington	9260	Urban	1.0322	1.0322	49420	Urban	1.0322

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51000	Barbour County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51010	Berkeley County, W Virginia	8840	Urban	1.0971	0.9715	25180	Urban	1.0343
51020	Boone County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51030	Braxton County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51040	Brooke County, W Virginia	8080	Urban	0.8280	0.8280	48260	Urban	0.8280
51050	Cabell County, W Virginia	3400	Urban	0.9564	0.9564	26580	Urban	0.9564
51060	Calhoun County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51070	Clay County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51080	Doddridge County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51090	Fayette County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51100	Gilmer County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51110	Grant County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51120	Greenbrier County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51130	Hampshire County, W Virginia	51	Rural	0.8083	1.0496	49020	Urban	0.9290
51140	Hancock County, W Virginia	8080	Urban	0.8280	0.8280	48260	Urban	0.8280
51150	Hardy County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51160	Harrison County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51170	Jackson County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51180	Jefferson County, W Virginia	8840	Urban	1.0971	1.1023	47894	Urban	1.0997
51190	Kanawha County, W Virginia	1480	Urban	0.8876	0.8876	16620	Urban	0.8876
51200	Lewis County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51210	Lincoln County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51220	Logan County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51230	Mc Dowell County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51240	Marion County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51250	Marshall County, W Virginia	9000	Urban	0.7449	0.7449	48540	Urban	0.7449
51260	Mason County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51270	Mercer County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51280	Mineral County, W Virginia	1900	Urban	0.8662	0.8662	19060	Urban	0.8662
51290	Mingo County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51300	Monongalia County, W Virginia	51	Rural	0.8083	0.8730	34060	Urban	0.8407
51310	Monroe County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51320	Morgan County, W Virginia	51	Rural	0.8083	0.9715	25180	Urban	0.8899
51330	Nicholas County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51340	Ohio County, W Virginia	9000	Urban	0.7449	0.7449	48540	Urban	0.7449
51350	Pendleton County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51360	Pleasants County, W Virginia	51	Rural	0.8083	0.8288	37620	Urban	0.8186
51370	Pocahontas County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51380	Preston County, W Virginia	51	Rural	0.8083	0.8730	34060	Urban	0.8407
51390	Putnam County, W Virginia	1480	Urban	0.8876	0.8876	16620	Urban	0.8876
51400	Raleigh County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51410	Randolph County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51420	Ritchie County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
51430	Roane County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51440	Summers County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51450	Taylor County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51460	Tucker County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51470	Tyler County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51480	Upshur County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51490	Wayne County, W Virginia	3400	Urban	0.9564	0.9564	26580	Urban	0.9564
51500	Webster County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51510	Wetzel County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
51520	Wirt County, W Virginia	51	Rural	0.8083	0.8288	37620	Urban	0.8186
51530	Wood County, W Virginia	6020	Urban	0.8288	0.8288	37620	Urban	0.8288
51540	Wyoming County, W Virginia	51	Rural	0.8083	0.7865	99951	Rural	0.7974
52000	Adams County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52010	Ashland County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52020	Barron County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52030	Bayfield County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52040	Brown County, Wisconsin	3080	Urban	0.9586	0.9590	24580	Urban	0.9588
52050	Buffalo County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52060	Burnett County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52070	Calumet County, Wisconsin	0460	Urban	0.9115	0.9131	11540	Urban	0.9123
52080	Chippewa County, Wisconsin	2290	Urban	0.9139	0.9139	20740	Urban	0.9139
52090	Clark County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52100	Columbia County, Wisconsin	52	Rural	0.9498	1.0306	31540	Urban	0.9902
52110	Crawford County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52120	Dane County, Wisconsin	4720	Urban	1.0395	1.0306	31540	Urban	1.0351
52130	Dodge County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52140	Door County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52150	Douglas County, Wisconsin	2240	Urban	1.0356	1.0340	20260	Urban	1.0348
52160	Dunn County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52170	Eau Claire County, Wisconsin	2290	Urban	0.9139	0.9139	20740	Urban	0.9139
52180	Florence County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52190	Fond Du Lac County, Wisconsin	52	Rural	0.9498	0.9897	22540	Urban	0.9698
52200	Forest County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52210	Grant County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52220	Green County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52230	Green Lake County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52240	Iowa County, Wisconsin	52	Rural	0.9498	1.0306	31540	Urban	0.9902
52250	Iron County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52260	Jackson County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52270	Jefferson County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52280	Juneau County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52290	Kenosha County, Wisconsin	3800	Urban	0.9772	1.0342	29404	Urban	1.0057
52300	Kewaunee County, Wisconsin	52	Rural	0.9498	0.9590	24580	Urban	0.9544

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
52310	La Crosse County, Wisconsin	3870	Urban	0.9289	0.9289	29100	Urban	0.9289
52320	Lafayette County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52330	Langlade County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52340	Lincoln County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52350	Manitowoc County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52360	Marathon County, Wisconsin	8940	Urban	0.9570	0.9570	48140	Urban	0.9570
52370	Marinette County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52380	Marquette County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52381	Menominee County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52390	Milwaukee County, Wisconsin	5080	Urban	1.0076	1.0076	33340	Urban	1.0076
52400	Monroe County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52410	Oconto County, Wisconsin	52	Rural	0.9498	0.9590	24580	Urban	0.9544
52420	Oneida County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52430	Outagamie County, Wisconsin	0460	Urban	0.9115	0.9131	11540	Urban	0.9123
52440	Ozaukee County, Wisconsin	5080	Urban	1.0076	1.0076	33340	Urban	1.0076
52450	Pepin County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52460	Pierce County, Wisconsin	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
52470	Polk County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52480	Portage County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52490	Price County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52500	Racine County, Wisconsin	6600	Urban	0.9045	0.9045	39540	Urban	0.9045
52510	Richland County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52520	Rock County, Wisconsin	3620	Urban	0.9583	0.9583	27500	Urban	0.9583
52530	Rusk County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52540	St Croix County, Wisconsin	5120	Urban	1.1066	1.1066	33460	Urban	1.1066
52550	Sauk County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52560	Sawyer County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52570	Shawano County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52580	Sheboygan County, Wisconsin	7620	Urban	0.8948	0.8948	43100	Urban	0.8948
52590	Taylor County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52600	Trempealeau County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52610	Vernon County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52620	Vilas County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52630	Walworth County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52640	Washburn County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52650	Washington County, Wisconsin	5080	Urban	1.0076	1.0076	33340	Urban	1.0076
52660	Waukesha County, Wisconsin	5080	Urban	1.0076	1.0076	33340	Urban	1.0076
52670	Waupaca County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52680	Waushara County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
52690	Winnebago County, Wisconsin	0460	Urban	0.9115	0.9099	36780	Urban	0.9107
52700	Wood County, Wisconsin	52	Rural	0.9498	0.9492	99952	Rural	0.9495
53000	Albany County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53010	Big Horn County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Trans. Wage Index *
53020	Campbell County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53030	Carbon County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53040	Converse County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53050	Crook County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53060	Fremont County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53070	Goshen County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53080	Hot Springs County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53090	Johnson County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53100	Laramie County, Wyoming	1580	Urban	0.8980	0.8980	16940	Urban	0.8980
53110	Lincoln County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53120	Natrona County, Wyoming	1350	Urban	0.9243	0.9243	16220	Urban	0.9243
53130	Niobrara County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53140	Park County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53150	Platte County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53160	Sheridan County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53170	Sublette County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53180	Sweetwater County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53190	Teton County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53200	Uinta County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53210	Washakie County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
53220	Weston County, Wyoming	53	Rural	0.9182	0.9182	99953	Rural	0.9182
65010	Agana County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65020	Agana Heights County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65030	Agat County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65040	Asan County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65050	Barrigada County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65060	Chalan Pago County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65070	Dededo County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65080	Inarajan County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65090	Maite County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65100	Mangilao County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65110	Merizo County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65120	Mongmong County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65130	Ordot County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65140	Piti County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65150	Santa Rita County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65160	Sinajana County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65170	Talofof County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65180	Tamuning County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65190	Toto County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65200	Umatac County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65210	Yigo County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611
65220	Yona County, Guam	65	Rural	0.9611	0.9611	99965	Rural	0.9611

* Transition Wage Index is comprised of 50 percent of FY 2006 MSA-based wage

index and 50 percent of FY 2006 CBSA based wage index (both based on FY 2001 hospital wage data).

**Table 2 - FY 2006 IRF PPS Hold Harmless Areas
(For Federal Fiscal Years 2006 and 2007)**

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Transition Wage Index *
01030	Bibb County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
01100	Chilton County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
01300	Geneva County, Alabama	01	Rural	0.7637	0.7537	20020	Urban	0.7587
01310	Greene County, Alabama	01	Rural	0.7637	0.8336	46220	Urban	0.7987
01320	Hale County, Alabama	01	Rural	0.7637	0.8336	46220	Urban	0.7987
01330	Henry County, Alabama	01	Rural	0.7637	0.7537	20020	Urban	0.7587
01420	Lowndes County, Alabama	01	Rural	0.7637	0.8300	33860	Urban	0.7969
01630	Walker County, Alabama	01	Rural	0.7637	0.9157	13820	Urban	0.8397
02090	Fairbanks County, Alaska	02	Rural	1.1637	1.1146	21820	Urban	1.1392
02170	Matanuska County, Alaska	02	Rural	1.1637	1.2165	11260	Urban	1.1901
03120	Yavapai County, Arizona	03	Rural	0.9140	0.9892	39140	Urban	0.9516
04120	Cleveland County, Arkansas	04	Rural	0.7703	0.8673	38220	Urban	0.8188
04230	Franklin County, Arkansas	04	Rural	0.7703	0.8283	22900	Urban	0.7993
04250	Garland County, Arkansas	04	Rural	0.7703	0.9249	26300	Urban	0.8476
04260	Grant County, Arkansas	04	Rural	0.7703	0.8826	30780	Urban	0.8265
04390	Lincoln County, Arkansas	04	Rural	0.7703	0.8673	38220	Urban	0.8188
04430	Madison County, Arkansas	04	Rural	0.7703	0.8636	22220	Urban	0.8170
04520	Perry County, Arkansas	04	Rural	0.7703	0.8826	30780	Urban	0.8265
04550	Poinsett County, Arkansas	04	Rural	0.7703	0.8144	27860	Urban	0.7924
05120	Imperial County, California	05	Rural	1.0297	0.8856	20940	Urban	0.9577
05150	Kings County, California	05	Rural	1.0297	0.9296	25260	Urban	0.9797
05450	San Benito County, California	05	Rural	1.0297	1.4722	41940	Urban	1.2510
06090	Clear Creek County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06190	Elbert County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06230	Gilpin County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06460	Park County, Colorado	06	Rural	0.9368	1.0904	19740	Urban	1.0136
06590	Teller County, Colorado	06	Rural	0.9368	0.9792	17820	Urban	0.9580
10010	Baker County, Florida	10	Rural	0.8721	0.9537	27260	Urban	0.9129
10200	Gilchrist County, Florida	10	Rural	0.8721	0.9459	23540	Urban	0.9090
10300	Indian River County, Florida	10	Rural	0.8721	0.9477	46940	Urban	0.9099
10320	Jefferson County, Florida	10	Rural	0.8721	0.8655	45220	Urban	0.8688
10640	Wakulla County, Florida	10	Rural	0.8721	0.8655	45220	Urban	0.8688
11020	Baker County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
11110	Brantley County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11120	Brooks County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11150	Burke County, Georgia	11	Rural	0.8247	0.9154	12260	Urban	0.8701

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Transition Wage Index *
11160	Butts County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11330	Crawford County, Georgia	11	Rural	0.8247	0.9887	31420	Urban	0.9067
11350	Dawson County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11420	Echols County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11460	Floyd County, Georgia	11	Rural	0.8247	0.8878	40660	Urban	0.8563
11490	Glynn County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11550	Hall County, Georgia	11	Rural	0.8247	0.9557	23580	Urban	0.8902
11570	Haralson County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11590	Heard County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11611	Jasper County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11651	Lamar County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11652	Lanier County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11680	Liberty County, Georgia	11	Rural	0.8247	0.7715	25980	Urban	0.7981
11691	Long County, Georgia	11	Rural	0.8247	0.7715	25980	Urban	0.7981
11700	Lowndes County, Georgia	11	Rural	0.8247	0.8341	46660	Urban	0.8294
11703	Mc Intosh County, Georgia	11	Rural	0.8247	1.1933	15260	Urban	1.0090
11730	Marion County, Georgia	11	Rural	0.8247	0.8690	17980	Urban	0.8469
11740	Meriwether County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11760	Monroe County, Georgia	11	Rural	0.8247	0.9887	31420	Urban	0.9067
11772	Murray County, Georgia	11	Rural	0.8247	0.9558	19140	Urban	0.8903
11801	Oglethorpe County, Georgia	11	Rural	0.8247	1.0202	12020	Urban	0.9225
11821	Pike County, Georgia	11	Rural	0.8247	0.9971	12060	Urban	0.9109
11885	Terrell County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
11970	Whitfield County, Georgia	11	Rural	0.8247	0.9558	19140	Urban	0.8903
11980	Worth County, Georgia	11	Rural	0.8247	1.1266	10500	Urban	0.9757
13070	Boise County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13090	Bonneville County, Idaho	13	Rural	0.8826	0.9059	26820	Urban	0.8943
13200	Franklin County, Idaho	13	Rural	0.8826	0.9094	30860	Urban	0.8960
13220	Gem County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13250	Jefferson County, Idaho	13	Rural	0.8826	0.9059	26820	Urban	0.8943
13270	Kootenai County, Idaho	13	Rural	0.8826	0.9339	17660	Urban	0.9083
13340	Nez Perce County, Idaho	13	Rural	0.8826	0.9314	30300	Urban	0.9070
13360	Owyhee County, Idaho	13	Rural	0.8826	0.9352	14260	Urban	0.9089
13380	Power County, Idaho	13	Rural	0.8826	0.9601	38540	Urban	0.9214
14020	Bond County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14060	Calhoun County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14350	Ford County, Illinois	14	Rural	0.8340	0.9527	16580	Urban	0.8934
14670	Macoupin County, Illinois	14	Rural	0.8340	0.9076	41180	Urban	0.8708
14700	Marshall County, Illinois	14	Rural	0.8340	0.8886	37900	Urban	0.8613
14740	Mercer County, Illinois	14	Rural	0.8340	0.8773	19340	Urban	0.8557
14820	Piatt County, Illinois	14	Rural	0.8340	0.9527	16580	Urban	0.8934
14960	Stark County, Illinois	14	Rural	0.8340	0.8886	37900	Urban	0.8613

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Transition Wage Index *
14982	Vermilion County, Illinois	14	Rural	0.8340	0.8392	19180	Urban	0.8366
15020	Bartholomew County, Indiana	15	Rural	0.8736	0.9388	18020	Urban	0.9062
15030	Benton County, Indiana	15	Rural	0.8736	0.9067	29140	Urban	0.8902
15060	Brown County, Indiana	15	Rural	0.8736	1.0113	26900	Urban	0.9425
15070	Carroll County, Indiana	15	Rural	0.8736	0.9067	29140	Urban	0.8902
15230	Franklin County, Indiana	15	Rural	0.8736	0.9516	17140	Urban	0.9126
15250	Gibson County, Indiana	15	Rural	0.8736	0.8372	21780	Urban	0.8554
15270	Greene County, Indiana	15	Rural	0.8736	0.8587	14020	Urban	0.8662
15360	Jasper County, Indiana	15	Rural	0.8736	0.9310	23844	Urban	0.9023
15450	La Porte County, Indiana	15	Rural	0.8736	0.9332	33140	Urban	0.9034
15550	Newton County, Indiana	15	Rural	0.8736	0.9310	23844	Urban	0.9023
15590	Owen County, Indiana	15	Rural	0.8736	0.8587	14020	Urban	0.8662
15660	Putnam County, Indiana	15	Rural	0.8736	1.0113	26900	Urban	0.9425
15760	Sullivan County, Indiana	15	Rural	0.8736	0.8517	45460	Urban	0.8627
15870	Washington County, Indiana	15	Rural	0.8736	0.9122	31140	Urban	0.8929
16050	Benton County, Iowa	16	Rural	0.8550	0.8975	16300	Urban	0.8763
16080	Bremer County, Iowa	16	Rural	0.8550	0.8633	47940	Urban	0.8592
16370	Grundy County, Iowa	16	Rural	0.8550	0.8633	47940	Urban	0.8592
16380	Guthrie County, Iowa	16	Rural	0.8550	0.9266	19780	Urban	0.8908
16420	Harrison County, Iowa	16	Rural	0.8550	0.9754	36540	Urban	0.9152
16520	Jones County, Iowa	16	Rural	0.8550	0.8975	16300	Urban	0.8763
16600	Madison County, Iowa	16	Rural	0.8550	0.9266	19780	Urban	0.8908
16640	Mills County, Iowa	16	Rural	0.8550	0.9754	36540	Urban	0.9152
16840	Story County, Iowa	16	Rural	0.8550	0.9479	11180	Urban	0.9015
16910	Washington County, Iowa	16	Rural	0.8550	0.9654	26980	Urban	0.9102
17210	Doniphan County, Kansas	17	Rural	0.8087	1.0013	41140	Urban	0.9050
17290	Franklin County, Kansas	17	Rural	0.8087	0.9629	28140	Urban	0.8858
17420	Jackson County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17430	Jefferson County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17530	Linn County, Kansas	17	Rural	0.8087	0.9629	28140	Urban	0.8858
17690	Osage County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
17950	Sumner County, Kansas	17	Rural	0.8087	0.9457	48620	Urban	0.8772
17980	Wabaunsee County, Kansas	17	Rural	0.8087	0.8904	45820	Urban	0.8496
18110	Bracken County, Kentucky	18	Rural	0.7844	0.9516	17140	Urban	0.8680
18291	Edmonson County, Kentucky	18	Rural	0.7844	0.8140	14540	Urban	0.7992
18450	Hancock County, Kentucky	18	Rural	0.7844	0.8434	36980	Urban	0.8139
18460	Hardin County, Kentucky	18	Rural	0.7844	0.8684	21060	Urban	0.8264
18510	Henry County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18610	Larue County, Kentucky	18	Rural	0.7844	0.8684	21060	Urban	0.8264
18740	Mc Lean County, Kentucky	18	Rural	0.7844	0.8434	36980	Urban	0.8139
18801	Meade County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18890	Nelson County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483

SSA State/ County Code	County name	MSA Number	MSA Urban / Rural	2006 MSA-based WI	2006 CBSA-based WI	CBSA Number	CBSA Urban / Rural	Transition Wage Index *
18978	Shelby County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18980	Spencer County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18983	Trigg County, Kentucky	18	Rural	0.7844	0.8022	17300	Urban	0.7933
18984	Trimble County, Kentucky	18	Rural	0.7844	0.9122	31140	Urban	0.8483
18986	Warren County, Kentucky	18	Rural	0.7844	0.8140	14540	Urban	0.7992
18989	Webster County, Kentucky	18	Rural	0.7844	0.8372	21780	Urban	0.8108
19110	Cameron County, Louisiana	19	Rural	0.7290	0.7935	29340	Urban	0.7613
19150	De Soto County, Louisiana	19	Rural	0.7290	0.9132	43340	Urban	0.8211
19180	East Feliciana County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19210	Grant County, Louisiana	19	Rural	0.7290	0.8171	10780	Urban	0.7731
19230	Iberville County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19380	Pointe Coupee County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19450	St Helena County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
19550	Union County, Louisiana	19	Rural	0.7290	0.7903	33740	Urban	0.7597
19620	West Feliciana County, Louisiana	19	Rural	0.7290	0.8319	12940	Urban	0.7805
21190	Somerset County, Maryland	21	Rural	0.9179	0.9123	41540	Urban	0.9151
21220	Wicomico County, Maryland	21	Rural	0.9179	0.9123	41540	Urban	0.9151
22060	Franklin County, Massachusetts	22	Rural	1.0216	1.0176	44140	Urban	1.0196
23070	Barry County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
23130	Cass County, Michigan	23	Rural	0.8740	0.9447	43780	Urban	0.9094
23330	Ionia County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
23610	Newaygo County, Michigan	23	Rural	0.8740	0.9420	24340	Urban	0.9080
24080	Carlton County, Minnesota	24	Rural	0.9339	1.0340	20260	Urban	0.9840
24190	Dodge County, Minnesota	24	Rural	0.9339	1.1504	40340	Urban	1.0422
24780	Wabasha County, Minnesota	24	Rural	0.9339	1.1504	40340	Urban	1.0422
25140	Copiah County, Mississippi	25	Rural	0.7583	0.8291	27140	Urban	0.7937
25190	George County, Mississippi	25	Rural	0.7583	0.7974	37700	Urban	0.7779
25460	Marshall County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
25550	Perry County, Mississippi	25	Rural	0.7583	0.7362	25620	Urban	0.7473
25630	Simpson County, Mississippi	25	Rural	0.7583	0.8291	27140	Urban	0.7937
25650	Stone County, Mississippi	25	Rural	0.7583	0.8950	25060	Urban	0.8267
25680	Tate County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
25710	Tunica County, Mississippi	25	Rural	0.7583	0.9217	32820	Urban	0.8400
26060	Bates County, Missouri	26	Rural	0.7829	0.9629	28140	Urban	0.8729
26120	Caldwell County, Missouri	26	Rural	0.7829	0.9629	28140	Urban	0.8729
26130	Callaway County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26250	Cole County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26270	Crawford County, Missouri	26	Rural	0.7829	0.9076	41180	Urban	0.8453
26290	Dallas County, Missouri	26	Rural	0.7829	0.8557	44180	Urban	0.8193

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26310	De Kalb County, Missouri	26	Rural	0.7829	1.0013	41140	Urban	0.8921
26440	Howard County, Missouri	26	Rural	0.7829	0.8396	17860	Urban	0.8113
26590	Mc Donald County, Missouri	26	Rural	0.7829	0.8636	22220	Urban	0.8233
26670	Moniteau County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26750	Osage County, Missouri	26	Rural	0.7829	0.8338	27620	Urban	0.8084
26821	Polk County, Missouri	26	Rural	0.7829	0.8557	44180	Urban	0.8193
26992	Washington County, Missouri	26	Rural	0.7829	0.9076	41180	Urban	0.8453
27040	Carbon County, Montana	27	Rural	0.8701	0.8961	13740	Urban	0.8831
28250	Dixon County, Nebraska	28	Rural	0.9035	0.9070	43580	Urban	0.9053
28770	Saunders County, Nebraska	28	Rural	0.9035	0.9754	36540	Urban	0.9395
28790	Seward County, Nebraska	28	Rural	0.9035	1.0208	30700	Urban	0.9622
29120	Carson City County, Nevada	29	Rural	0.9832	1.0352	16180	Urban	1.0092
29140	Storey County, Nevada	29	Rural	0.9832	1.0456	39900	Urban	1.0144
32220	San Juan County, New Mexico	32	Rural	0.8529	0.8049	22140	Urban	0.8289
32280	Torrance County, New Mexico	32	Rural	0.8529	1.0485	10740	Urban	0.9507
33730	Tompkins County, New York	33	Rural	0.8403	0.9589	27060	Urban	0.8996
33740	Ulster County, New York	33	Rural	0.8403	0.9000	28740	Urban	0.8702
34030	Anson County, N Carolina	34	Rural	0.8500	0.9743	16740	Urban	0.9122
34390	Greene County, N Carolina	34	Rural	0.8500	0.9183	24780	Urban	0.8842
34430	Haywood County, N Carolina	34	Rural	0.8500	0.9191	11700	Urban	0.8846
34440	Henderson County, N Carolina	34	Rural	0.8500	0.9191	11700	Urban	0.8846
34460	Hoke County, N Carolina	34	Rural	0.8500	0.9363	22180	Urban	0.8932
34700	Pender County, N Carolina	34	Rural	0.8500	0.9237	48900	Urban	0.8869
34720	Person County, N Carolina	34	Rural	0.8500	1.0363	20500	Urban	0.9432
34780	Rockingham County, N Carolina	34	Rural	0.8500	0.9190	24660	Urban	0.8845
36220	Erie County, Ohio	36	Rural	0.8759	0.9017	41780	Urban	0.8888
36600	Morrow County, Ohio	36	Rural	0.8759	0.9737	18140	Urban	0.9248
36630	Ottawa County, Ohio	36	Rural	0.8759	0.9524	45780	Urban	0.9142
36690	Preble County, Ohio	36	Rural	0.8759	0.9303	19380	Urban	0.9031
36810	Union County, Ohio	36	Rural	0.8759	0.9737	18140	Urban	0.9248
37250	Grady County, Oklahoma	37	Rural	0.7537	0.8982	36420	Urban	0.8260
37390	Le Flore County, Oklahoma	37	Rural	0.7537	0.8283	22900	Urban	0.7910
37400	Lincoln County, Oklahoma	37	Rural	0.7537	0.8982	36420	Urban	0.8260
37550	Okmulgee County, Oklahoma	37	Rural	0.7537	0.8690	46140	Urban	0.8114
37580	Pawnee County, Oklahoma	37	Rural	0.7537	0.8690	46140	Urban	0.8114
38080	Deschutes County, Oregon	38	Rural	1.0049	1.0603	13460	Urban	1.0326
39070	Armstrong County, Pennsylvania	39	Rural	0.8348	0.8736	38300	Urban	0.8542
40050	Aibonito County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40080	Arroyo County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026

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40100	Barranquitas County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40190	Ciales County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40270	Guanica County, Puerto Rico	40	Rural	0.4047	0.4493	49500	Urban	0.4270
40280	Guayama County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026
40350	Isabela County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40390	Lajas County, Puerto Rico	40	Rural	0.4047	0.5240	41900	Urban	0.4644
40400	Lares County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40470	Maunabo County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40530	Orocovis County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40540	Patillas County, Puerto Rico	40	Rural	0.4047	0.4005	25020	Urban	0.4026
40570	Quebradillas County, Puerto Rico	40	Rural	0.4047	0.4645	41980	Urban	0.4346
40580	Rincon County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
40660	San Sebastian County, Puerto Rico	40	Rural	0.4047	0.4280	10380	Urban	0.4164
42080	Calhoun County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42150	Darlington County, S Carolina	42	Rural	0.8640	0.8833	22500	Urban	0.8737
42190	Fairfield County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42270	Kershaw County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
42290	Laurens County, S Carolina	42	Rural	0.8640	0.9557	24860	Urban	0.9099
42400	Saluda County, S Carolina	42	Rural	0.8640	0.9392	17900	Urban	0.9016
43430	Mc Cook County, S Dakota	43	Rural	0.8393	0.9441	43620	Urban	0.8917
43460	Meade County, S Dakota	43	Rural	0.8393	0.8912	39660	Urban	0.8653
43620	Turner County, S Dakota	43	Rural	0.8393	0.9441	43620	Urban	0.8917
43630	Union County, S Dakota	43	Rural	0.8393	0.9070	43580	Urban	0.8732
44050	Bradley County, Tennessee	44	Rural	0.7876	0.7844	17420	Urban	0.7860
44070	Cannon County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44280	Grainger County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44310	Hamblen County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44400	Hickman County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44440	Jefferson County, Tennessee	44	Rural	0.7876	0.7790	34100	Urban	0.7833
44550	Macon County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44690	Polk County, Tennessee	44	Rural	0.7876	0.7844	17420	Urban	0.7860
44760	Sequatchie County, Tennessee	44	Rural	0.7876	0.9207	16860	Urban	0.8542
44790	Smith County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981
44800	Stewart County, Tennessee	44	Rural	0.7876	0.8022	17300	Urban	0.7949
44840	Trousdale County, Tennessee	44	Rural	0.7876	1.0086	34980	Urban	0.8981

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45030	Aransas County, Texas	45	Rural	0.7910	0.8647	18580	Urban	0.8279
45050	Armstrong County, Texas	45	Rural	0.7910	0.9178	11100	Urban	0.8544
45060	Atascosa County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45070	Austin County, Texas	45	Rural	0.7910	0.9973	26420	Urban	0.8942
45090	Bandera County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45221	Burleson County, Texas	45	Rural	0.7910	0.9243	17780	Urban	0.8577
45224	Calhoun County, Texas	45	Rural	0.7910	0.8470	47020	Urban	0.8190
45230	Callahan County, Texas	45	Rural	0.7910	0.7850	10180	Urban	0.7880
45251	Carson County, Texas	45	Rural	0.7910	0.9178	11100	Urban	0.8544
45291	Clay County, Texas	45	Rural	0.7910	0.8332	48660	Urban	0.8121
45362	Crosby County, Texas	45	Rural	0.7910	0.8777	31180	Urban	0.8344
45400	Delta County, Texas	45	Rural	0.7910	1.0074	19124	Urban	0.8992
45561	Goliad County, Texas	45	Rural	0.7910	0.8470	47020	Urban	0.8190
45672	Irion County, Texas	45	Rural	0.7910	0.8167	41660	Urban	0.8039
45721	Jones County, Texas	45	Rural	0.7910	0.7850	10180	Urban	0.7880
45731	Kendall County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45752	Lampasas County, Texas	45	Rural	0.7910	0.9242	28660	Urban	0.8576
45792	Medina County, Texas	45	Rural	0.7910	0.9003	41700	Urban	0.8457
45878	Robertson County, Texas	45	Rural	0.7910	0.9243	17780	Urban	0.8577
45881	Rusk County, Texas	45	Rural	0.7910	0.8801	30980	Urban	0.8356
45884	San Jacinto County, Texas	45	Rural	0.7910	0.9973	26420	Urban	0.8942
45973	Wise County, Texas	45	Rural	0.7910	0.9472	23104	Urban	0.8691
46020	Cache County, Utah	46	Rural	0.8843	0.9094	30860	Urban	0.8969
46110	Juab County, Utah	46	Rural	0.8843	0.9588	39340	Urban	0.9216
46140	Morgan County, Utah	46	Rural	0.8843	0.9216	36260	Urban	0.9030
46210	Summit County, Utah	46	Rural	0.8843	0.9561	41620	Urban	0.9202
46220	Tooele County, Utah	46	Rural	0.8843	0.9561	41620	Urban	0.9202
46260	Washington County, Utah	46	Rural	0.8843	0.9458	41100	Urban	0.9151
49030	Amelia County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49050	Appomattox County, Virginia	49	Rural	0.8479	0.9017	31340	Urban	0.8748
49160	Caroline County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49220	Craig County, Virginia	49	Rural	0.8479	0.8415	40220	Urban	0.8447
49240	Cumberland County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49330	Franklin County, Virginia	49	Rural	0.8479	0.8415	40220	Urban	0.8447
49340	Frederick County, Virginia	49	Rural	0.8479	1.0496	49020	Urban	0.9488
49350	Giles County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49421	Harrisonburg City County, Virginia	49	Rural	0.8479	0.9275	25500	Urban	0.8877
49480	King And Queen County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49500	King William County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49540	Louisa County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49600	Montgomery County,	49	Rural	0.8479	0.7951	13980	Urban	0.8215

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	Virginia							
49620	Nelson County, Virginia	49	Rural	0.8479	1.0294	16820	Urban	0.9387
49770	Pulaski County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49771	Radford City County, Virginia	49	Rural	0.8479	0.7951	13980	Urban	0.8215
49820	Rockingham County, Virginia	49	Rural	0.8479	0.9275	25500	Urban	0.8877
49900	Surry County, Virginia	49	Rural	0.8479	0.8894	47260	Urban	0.8687
49910	Sussex County, Virginia	49	Rural	0.8479	0.9397	40060	Urban	0.8938
49962	Winchester City County, Virginia	49	Rural	0.8479	1.0496	49020	Urban	0.9488
50010	Asotin County, Washington	50	Rural	1.0072	0.9314	30300	Urban	0.9693
50030	Chelan County, Washington	50	Rural	1.0072	0.9427	48300	Urban	0.9750
50070	Cowlitz County, Washington	50	Rural	1.0072	1.0224	31020	Urban	1.0148
50080	Douglas County, Washington	50	Rural	1.0072	0.9427	48300	Urban	0.9750
50280	Skagit County, Washington	50	Rural	1.0072	1.0576	34580	Urban	1.0324
50290	Skamania County, Washington	50	Rural	1.0072	1.1403	38900	Urban	1.0738
51020	Boone County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51070	Clay County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51130	Hampshire County, W Virginia	51	Rural	0.8083	1.0496	49020	Urban	0.9290
51210	Lincoln County, W Virginia	51	Rural	0.8083	0.8876	16620	Urban	0.8480
51300	Monongalia County, W Virginia	51	Rural	0.8083	0.8730	34060	Urban	0.8407
51320	Morgan County, W Virginia	51	Rural	0.8083	0.9715	25180	Urban	0.8899
51360	Pleasants County, W Virginia	51	Rural	0.8083	0.8288	37620	Urban	0.8186
51380	Preston County, W Virginia	51	Rural	0.8083	0.8730	34060	Urban	0.8407
51520	Wirt County, W Virginia	51	Rural	0.8083	0.8288	37620	Urban	0.8186
52100	Columbia County, Wisconsin	52	Rural	0.9498	1.0306	31540	Urban	0.9902
52190	Fond Du Lac County, Wisconsin	52	Rural	0.9498	0.9897	22540	Urban	0.9698
52240	Iowa County, Wisconsin	52	Rural	0.9498	1.0306	31540	Urban	0.9902
52300	Kewaunee County, Wisconsin	52	Rural	0.9498	0.9590	24580	Urban	0.9544
52410	Oconto County, Wisconsin	52	Rural	0.9498	0.9590	24580	Urban	0.9544

* Transition Wage Index is comprised of 50 percent of FY 2006 MSA-based wage index and 50 percent of FY 2006 CBSA based wage index (both based on FY 2001 hospital wage data).