DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

December 30, 2009

Report Number: A-07-09-02758

Mr. Michael Smith
Assistant Vice President, Medicare Part A Audit
Noridian Administrative Services
P.O. Box 6720
Fargo, North Dakota 58108

Dear Mr. Smith:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Geographic Classification of Skagit Valley Hospital for Medicare Operating Disproportionate Share Hospital Payment." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, the final report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact James Korn, Audit Manager, at (303) 844-7153 or through email at James.Korn@oig.hhs.gov. Please refer to report number A-07-09-02758 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GEOGRAPHIC CLASSIFICATION OF SKAGIT VALLEY HOSPITAL FOR MEDICARE OPERATING DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Daniel R. Levinson
Inspector General

December 2009
A-07-09-02758

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare hospitals submit cost reports to their Medicare fiscal intermediaries or Medicare administrative contractors (MAC) annually. (Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to transfer the functions of fiscal intermediaries to MACs by October 2011.) Each cost report is based on the hospital's financial and statistical records, and the hospital attests to the accuracy of the data when submitting its cost report. After acceptance of the cost report, the fiscal intermediary performs a tentative settlement. Before making final settlement, the fiscal intermediary reviews the cost report and, if necessary, conducts an audit. The fiscal intermediary then issues a notice of program reimbursement. As the final settlement document, the notice of program reimbursement shows whether the Medicare program owes the hospital or the hospital owes the Medicare program.

The cost report is used to report various Medicare payments, including an operating disproportionate share hospital (operating DSH) payment if a hospital is deemed eligible for reimbursement of operating costs because it treats a disproportionate share of low-income patients. Medicare fiscal intermediaries or MACs make determinations, based on Federal regulations, as to whether a hospital qualifies for a Medicare operating DSH payment and the size of the payment. These determinations depend on numerous factors, including whether the hospital is in an urban area or a rural area.

Skagit Valley Hospital (Skagit Valley) is a 137 bed, acute-care hospital located in Mount Vernon, Washington. Skagit Valley claimed an operating DSH adjustment of $2,159,331 on its cost report for the fiscal year ending December 31, 2004.

For the cost report reviewed, Skagit Valley's fiscal intermediary was Noridian Administrative Services, LLC (Noridian). Noridian is based in Fargo, North Dakota, and at the time of our audit served as the fiscal intermediary for hospitals in several states, including Washington.

OBJECTIVE

Our objective was to determine whether the geographic classifications used by Noridian to calculate the Medicare operating DSH adjustment resulted in an overpayment.

SUMMARY OF FINDINGS

Geographic classifications used by Noridian to calculate the Medicare operating DSH adjustment resulted in an overpayment at one hospital. Of the operating DSH adjustment of $2,159,331 that Skagit Valley claimed on its cost report for the fiscal year ending December 31, 2004, $417,591

was excessive because Noridian calculated the operating DSH adjustment as if the hospital was urban for the entire cost report period. However, Skagit Valley was rural for the period January 1, 2004, through September 30, 2004. This resulted in an operating DSH overpayment of $417,591.

This overpayment occurred because Noridian's internal controls did not always ensure that hospitals received Medicare operating DSH adjustments based upon the correct geographic classification.

RECOMMENDATION

We recommend that Noridian recover the $417,591 in Medicare operating DSH overpayment from Skagit Valley.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian did not concur with our findings and recommendation. While Noridian did not agree that an overpayment occurred, it initiated a reopening of the cost report to protect the government's right to recover an overpayment pending CMS's resolution of the audit findings. In addition, Noridian did not agree that it had insufficient controls in place to prevent an overpayment. Noridian's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Noridian's comments and the additional documentation it provided, we revised our report as it pertains to the sufficiency of Noridian's internal controls in order to describe the cause of the overpayment more precisely. We maintain that the remaining findings and recommendation are valid.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare hospitals submit cost reports to their Medicare fiscal intermediaries or Medicare administrative contractors (MAC) annually.[1] Each cost report is based on the hospital's financial and statistical records, and the hospital attests to the accuracy of the data when submitting its cost report. After acceptance of the cost report, the fiscal intermediary performs a tentative settlement. Before making final settlement, the fiscal intermediary reviews the cost report and, if necessary, conducts an audit.

The fiscal intermediary then issues a notice of program reimbursement. As the final settlement document, the notice of program reimbursement shows whether the Medicare program owes the hospital or the hospital owes the Medicare program.

The cost report is used to report various Medicare payments, including an operating disproportionate share hospital (operating DSH) payment if a hospital is deemed eligible for reimbursement of operating costs because it treats a disproportionate share of low-income patients. Medicare fiscal intermediaries or MACs make determinations, based on Federal regulations, as to whether a hospital qualifies for a Medicare operating DSH payment and the size of the payment. To determine whether a hospital is entitled to an operating DSH adjustment, the fiscal intermediary must calculate the disproportionate patient percentage (DPP). Then, using the DPP, together with the number of beds and the hospital's location (i.e., urban or rural), the fiscal intermediary must determine whether the hospital qualifies for an operating DSH payment. If the hospital's geographic classification changes during the cost reporting period, this determination must be made for each respective period.

Skagit Valley Hospital (Skagit Valley) is a 137 bed, acute-care hospital located in Mount Vernon, Washington. Skagit Valley claimed an operating DSH adjustment of $2,159,331 on its cost report for the fiscal year ending December 31, 2004.

For the cost report reviewed, Skagit Valley's fiscal intermediary was Noridian Administrative Services, LLC (Noridian). Noridian is based in Fargo, North Dakota, and at the time of our audit served as the fiscal intermediary for hospitals in several states, including Washington.

[1]Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to transfer the functions of carriers and fiscal intermediaries to MACs by October 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the geographic classifications used by Noridian to calculate the Medicare operating DSH adjustment resulted in an overpayment.

Scope

We reviewed the $2,159,331 Medicare operating DSH adjustment claimed on Skagit Valley's cost report for the fiscal year ending December 31, 2004.

We did not verify the accuracy of the factors in the Medicare operating DSH computation, other than to verify the accuracy of the geographic classification of the hospital.

We conducted our audit from June through December 2008.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws and regulations.

- We interviewed CMS officials to gain an understanding of how Medicare operating DSH payments are calculated.

- We obtained all cost reports from the Healthcare Cost Report Information System[2] for acute-care inpatient hospitals whose cost reporting periods ended in calendar years 2003 through 2006 as of March 31, 2007.

- We determined the geographic classification for all hospitals using data from the most recent U.S. Census to identify whether particular hospitals were geographically classified as rural or urban during our audit period. We then accounted for reclassifications done by the Medicare Geographic Classification Review Board and "Lugar" reclassifications (discussed below) in accordance with Section 1886(d)(8)(B) of the Act.

- We used the cost report data to recalculate the operating DSH payments based upon these geographic classifications to identify any hospitals that may have received an overpayment due to using an incorrect geographic classification. As a result of this process, we selected Skagit Valley's cost report for the fiscal year ending December 31, 2004, for further review.

[2]The Healthcare Cost Report Information System is a national database containing financial and statistical information extracted from hospital cost reports.

- We contacted Noridian and confirmed, for the applicable Federal fiscal years, how Skagit Valley was geographically classified and determined how Noridian calculated the operating DSH adjustment.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

Geographic classifications used by Noridian to calculate the Medicare operating DSH adjustment resulted in an overpayment at one hospital. Of the operating DSH adjustment of $2,159,331 that Skagit Valley claimed on its cost report for the fiscal year ending December 31, 2004, $417,591 was excessive because Noridian calculated the operating DSH adjustment as if the hospital was urban for the entire cost report period. However, Skagit Valley was rural for the period January 1, 2004, through September 30, 2004. This resulted in an operating DSH overpayment of $417,591.

FEDERAL REQUIREMENTS

Pursuant to 42 CFR § 412.106, hospitals that serve a disproportionate number of low-income patients may receive an additional Medicare operating DSH payment. Determinations as to whether a hospital qualifies for a Medicare operating DSH payment and the size of the payment depend in part on whether the hospital is in an urban area or a rural area.

The geographic classifications used to determine whether the hospital is in an urban area or a rural area are based upon the definitions in 42 CFR §§ 412.62(f) or 412.64, which generally identify an urban area as a metropolitan statistical area as defined by the Office of Management and Budget (OMB). On June 6, 2003, OMB began classifying geographic areas using the core-based statistical areas identified on the decennial census conducted in 2000. CMS deferred implementation of these definitions until October 1, 2004.

A hospital's geographic classification can be reclassified by the Medicare Geographic Classification Review Board through an application process in accordance with 42 CFR § 412.230. A hospital's geographic classification can also be deemed urban if that hospital meets certain criteria based on residents' commuting patterns and population density. These "Lugar" hospitals are located in rural counties and have been reclassified as urban under § 1886(d)(8)(B) of the Act.

OVERPAYMENT RECEIVED

Skagit Valley claimed an operating DSH overpayment of $417,591 because Noridian incorrectly calculated the operating DSH adjustment as if Skagit Valley was urban for the entire cost report period. However, Skagit Valley was rural for the period January 1, 2004, through

September 30, 2004, and for that time period Noridian should have calculated the operating DSH adjustment accordingly.

The OMB definitions then in effect geographically classified Skagit Valley as a rural hospital for the period January 1, 2004, through September 30, 2004. Effective October 1, 2004, Skagit Valley became an urban hospital with the transition to the use of core-based statistical areas identified on the decennial census conducted in 2000. However, Noridian calculated the operating DSH adjustment for the fiscal year ending December 31, 2004, as though Skagit Valley was urban for the entire cost report period.

This overpayment occurred because Noridian's internal controls did not always ensure that hospitals received Medicare operating DSH adjustments based upon the correct geographic classification.

RECOMMENDATION

We recommend that Noridian recover the $417,591 in Medicare operating DSH overpayment from Skagit Valley.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Noridian did not concur with our findings and recommendation. While Noridian did not agree that an overpayment occurred, it initiated a reopening of the cost report to protect the government's right to recover an overpayment pending CMS's resolution of the audit findings. A summary of Noridian's other pertinent comments and our response follows. Noridian's comments appear in their entirety as the Appendix.

After reviewing Noridian's comments and the additional documentation it provided, we revised one aspect of our report as discussed below. We maintain that the remaining findings and recommendation are valid.

Effective Date of Reclassification

Noridian Administrative Services, LLC, Comments

Noridian stated that, for the purposes of calculating the operating DSH payment, the geographic area where Skagit Valley resides was designated as an urban area effective June 6, 2003, which is the date that OMB issued Bulletin No. 03-04. According to Noridian, the definitions and recognition of the areas noted on the bulletin "take effect immediately." Noridian also said that CMS has not issued formal guidance identifying when these changes should become effective for the purposes of calculating DSH payments.

Office of Inspector General Response

Although the OMB Bulletin stated that its provisions would take effect immediately, OMB stated (in the same Bulletin) that when its definitions are used for nonstatistical programs, the sponsoring agency must ensure appropriate use. Accordingly, CMS announced that, with respect to Medicare hospital inpatient prospective payments systems (which would include the system to make Medicare operating DSH payments), it would delay implementation of the new and revised OMB definitions until the October 1, 2004, date mentioned earlier in this report.[3]

Single Geographic Classification for Each Cost Reporting Period

Noridian Administrative Services, LLC, Comments

Noridian stated a hospital can have only one geographical classification for a cost reporting period. It also said that according to 42 CFR § 412.106, the process to calculate operating DSH payments begins with the determination of whether a hospital is urban or rural for a cost reporting period, and added that the respective operating DSH payment is calculated based upon that geographic classification for the entire cost reporting period.

Office of Inspector General Response

In accordance with section 1886(d)(5)(F) of the Act, the operating DSH payment is an additional payment per discharge for hospitals serving a significantly disproportionate number of low-income patients. The determination as to whether a hospital qualifies for an operating DSH payment is based, in part, on the hospital's location. In cases where the hospital's location changes from rural to urban (or vice versa) during the applicable cost reporting period, the fiscal intermediary must twice determine whether the hospital qualifies for an operating DSH payment—once using the original location (e.g., rural) for the portion of the cost reporting period when that location was in effect, and then again using the revised location (e.g., urban) for the remaining portion of the cost reporting period.

Sufficiency of Internal Controls

Noridian Administrative Services, LLC, Comments

Noridian did not agree that the evidence supported the statement that the overpayment occurred "because Noridian had insufficient internal controls in place."

Office of Inspector General Response

After reviewing Noridian's comments, we revised our report as it pertains to the sufficiency of Noridian's internal controls in order to describe the cause of the overpayment more precisely.

[3] 69 Fed. Reg. 48916, 49026 – 49034 (August 11, 2004).

APPENDIX

APPENDIX: AUDITEE COMMENTS

NORIDIAN®
Administrative Services LLC

Medicare

P.O. Box 6720
Fargo, ND 58108-6720

August 26, 2009

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General, Region VII
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

Re: Re: Office of Inspector General report titled, "Review of Geographic Classification of Skagit Valley Hospital for Medicare Operating Disproportionate Share Hospital Payment", Report No. A-07-09-02758, July, 2009

Dear Mr. Cogley:

Thank you for the draft report entitled "Review of Geographic Classification of Skagit Valley Hospital for Medicare Operating Disproportionate Share Hospital Payment." We appreciate the opportunity to respond to the draft report's findings and recommendation. As explained below, NAS does not concur with the report's draft findings.

Noridian Administrative Services, LLC (NAS) supports the mission of the Office of Inspector General (OIG) to promote economy and efficiency throughout the Department of Health and Human Services. We look forward to the final conclusion of the OIG's 13 month-long effort to determine the proper geographic classification for one of the thousands of provider cost reports we have processed for the review period.

The regulations and statutes applicable to DSH payments require us to treat as urban any area defined by the Office of Management and Budget (OMB) as a Metropolitan Statistical Area (MSA) for operating DSH payment purposes. The provider in question is located in an area defined by the OMB as a MSA effective June, 2003. CMS did not delay recognition of urban status for DSH payment purposes. Applicable law governing DSH payments require a hospital to be either urban or rural for all of a particular cost reporting period. Because the applicable regulations and law require us to recognize as urban those areas OMB has defined as MSAs for the entire cost reporting period, we believe our determination was correct and no overpayment occurred. Our basis for non-concurrence with the draft report is explained more fully below:

The Office of Management and Budget formally classified the geographic area where Skagit Valley Hospital resides as urban on June 6, 2003, effective that date.

The OMB defines Metropolitan Statistical Areas (44 U.S.C. 3504(e)(3)). On June 6, 2003, OMB issued Bulletin No. 03-04 (exhibit 1) establishing the Mount Vernon-Anacortes, Washington as a

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MSA, OMB assigned code number 34580 to the newly recognized urban area. The stated purpose of the bulletin was to establish revised definitions for MSAs and recognize 49 new MSAs. OMB stated in paragraph "1. Purpose" that the definitions and recognition of the areas noted on the bulletin's attached lists "take effect immediately."

The Medicare statute and CMS regulations require recognition of those urban areas OMB has defined as MSAs.

Section 1886(d)(2)(D) of the Social Security Act defines "urban area" as "an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget).".

Pursuant to 42 CFR § 412.106, the factors considered in determining whether a hospital qualifies for a payment adjustment for DSH includes the hospital's location in an urban or rural area as "determined in accordance with the definitions in §412.62(f) or § 412.64".

Both of the regulations referenced define the urban area relevant to Skagit Valley Hospital exactly the same as follows:

> "(ii) The term urban area means—(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget." 42 CFR 412.62(f)(ii)
>
> (ii) The term urban area means— (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget 42 CFR 412.64(b)(ii)

Our DSH calculation reflects the geographical classification that Skagit Valley Hospital is entitled to based on the regulations and the statute.

The OIG states in its Findings and Recommendation that, "effective October 1, 2004, OMB revised its definitions and began classifying geographic areas using the core based statistical areas identified on the decennial census conducted in 2000." We do not believe this statement is correct. According to the June 6, 2003 OMB Bulletin, the definitions of the statistical areas in the bulletin's attached listings took effect immediately. On the U.S. Census Bureau Web site, the term core based statistical area" (CBSA) refers collectively to metropolitan and micropolitan statistical areas." Metropolitan Statistical Areas remain a geographical classification defined by OMB.

Throughout the preamble, comments, and text of the August 11, 2004 final rule (effective October 1, 2004) relied on by OIG, CMS refers to how it "would implement OMB's revised standards for defining MSAs," announced by OMB on June 6, 2003. CMS stated that the purposes of the final rule:

> "relate to our policies in established regulations under § 412.63(b) governing geographic classification of hospitals **for purposes of the wage index** and the **standardized amounts in determining the Federal rates for inpatient operating costs**. 69 FR 49077 (emphasis added)."

The regulation referenced above at 42 CFR §412.64 was codified into the regulations by the August 11, 2004 final rule. It does not change the definition of a Metropolitan Statistical Area. Rather, there are additions made that are not applicable to Mount Vernon which is covered under the regulatory definition of an MSA (i.e. not a Lugar hospital). Skagit Valley Hospital (SVH) resides within an MSA according to the revised regulation.

In none of the regulations relevant to DSH, nor anywhere in the August 11, 2004 final rule is there an effective date for purposes of DSH operating payments aside from one comment addressing a hospital redesignated from urban to rural, which is not applicable to SVH (see 69 FR 49077). The comment does however refer to the longstanding regulation at 42 CFR §412.102 that specifies a transition calculation that clearly uses the geographic classifications for the full cost reporting periods during the transition. The same is true for all of the transmittals concerning CBSAs. They predominately address wage index purposes.

CMS deferred implementation of the new MSAs until October 1, 2004 for wage index purposes only, as evidenced by the following CMS statements:

> "In the proposed rule, we stated that we would evaluate the new area designations and their possible effects on the Medicare hospital wage index." 68 FR 45394 (August 1, 2003)
>
> "As discussed previously, on June 6, 2003, OMB announced revised definitions of MSAs and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. **In order to implement these changes for the IPPS**, it is necessary to identify the new area designation for each county and hospital in the country. Because this process will have to be extensively reviewed and verified, we were unable to undertake it before publication of this final rule. Therefore, we are continuing to use MSAs based on OMB's definitions of MSAs prior to June 6, 2003." 68 FR 45475 (August 1, 2003)(emphasis added.)

CMS needed additional time to implement the changes with respect to the prospectively determined payment rates used for IPPS which are updated annually on October 1st. In order to adjust the prospective payment rates that are the main focus of 42 CFR §412.64 for labor differences, wage index values need to be determined for all of the areas. CMS is required to update these rates annually by October 1st. The DSH payment adjustment is not determined prospectively as part of IPPS. The DSH payment adjustment amount is determined by contractors for cost report settlement purposes. Contractors "make interim payments subject to a year-end settlement based upon the hospital's DSH percentage for the cost reporting period." (CMS Pub 100-04, Ch. 3, §20.3) The DSH payment process is not "implemented" every October 1st by CMS as is required for the payment rate updates for claims payment and prospective payment purposes. There was no change as a result of the August 1, 2003 final rule in the DSH regulation at 42 CFR § 412.106, nor in the new regulation to be used for defining an MSA at 42 CFR § 412.64(b) directing the Intermediary to do other than follow the plain meaning of the regulation for DSH payment purposes using OMB's definitions that define Skagit Valley as an MSA. That CMS could not physically implement the changes into the prospective payment rates is understandable. But to delay the hospital's urban status for DSH purposes contradicts the regulations and statute.

According to the plain language of the statute, a hospital can have only one geographical classification for a cost reporting period.

If CMS delayed recognition of the Mount Vernon-Anacortes MSA until 10/1/04, the DSH statute requires the Provider be considered urban for the entire cost reporting period. 42 CFR §412.106 allows an additional payment to IPPS hospitals if they qualify as a disproportionate share hospital. If the hospital qualifies under certain criteria, it is paid on a formula specified for those

criteria. Therefore, the process begins with a determination of whether the hospital qualifies as a disproportionate share hospital. A hospital is determined to be either urban or rural for a cost reporting period based on the law. Clause (v) of the DSH statute states:

> (v) In this subparagraph, ***a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period*** if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds--
>
> (I) 15 percent, ***if the hospital is located in an urban area and has 100 or more beds,***
>
> A ***hospital located in a rural area*** *and with 500 or more beds also* ***"serves a significantly disproportionate number of low income patients"*** for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary. 42 U.S.C. §1395ww(d)(5)(F)(v) (emphasis added).

According to the plain language of the statute, a hospital can only be eligible as either urban or rural during a cost reporting period.

The second step is to determine the payment amount. Per the law governing DSH payment formulas, for an urban hospital with 100 or more beds (a clause iv(I) hospital), the disproportionate share adjustment percentage is determined by clause (vii) as follows:

> "(vii) The formula used to determine the disproportionate share adjustment percentage ***for a cost reporting period*** for a hospital described in clause (iv)(I) is--
>
> (I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2--
>
> ...
>
> (d) for discharges occurring on or after October 1, 1994, (P-20.2)(.825)+5.88;" 42 U.S.C. §1395ww(d)(5)(F)(vii)(emphasis added.)

That is the calculation used by NAS. If considered rural, the hospital would have qualified as a rural hospital under clause (iv)(III) and the adjustment percentage calculated in accordance with clause (xii) ***for the cost reporting period***. If a hospital qualifies as urban with over 100 beds, (clause (iv)(I)) then the payment is calculated for the whole cost reporting period based on the applicable formula under clause (vii). The statute does not allow payment under that clause for only a portion of the cost reporting period. In this case the law requires that the hospital payment formula is from clause vii or xii for the cost reporting period. A hospital's DSH adjustment can only be based on its classification as rural or urban (but not both) for the cost reporting period.

NAS determined that SVH was urban for the cost reporting period consistent with clause (v) and determined the appropriate adjustment percentage in accordance with clause (vii) ***for the cost reporting period***.

To summarize, the regulations and the law require any areas defined by the OMB as an MSA to be treated as urban for operating DSH payment purposes. SVH is located in Mount Vernon,

Washington, defined by the OMB as an MSA effective June, 2003. While CMS delayed the implementation of the new MSAs for wage index purposes, it did not delay SVH's new urban status for DSH payment purposes. The DSH calculation as recommended by the OIG contradicts applicable law governing DSH that only allows a hospital to be either urban or rural for a cost reporting period.

NAS noted in the draft report's "summary of findings" section that an overpayment occurred "because Noridian had insufficient controls in place." We believe this statement to be unsupported by evidence. According to the draft report, all acute care inpatient hospital cost reports whose periods ended in calendar years 2003 through 2006 were obtained and geographic classification determined. Drawing from this universe, a single aspect of the DSH calculation was considered for a single cost report and 13 months later, a single exception noted. Considering the complexity and differing interpretations of the regulatory scheme, further complicated by the outcome of a once-a-decade census, we do not agree with the OIG's statement.

If the Centers for Medicare and Medicaid Services (CMS) confirms that the agency concurs with the final report's findings and directs NAS to recover a portion of the Medicare disproportionate share hospital (DSH) payment, NAS will abide by the agency's decision. NAS anticipated the prolonged period for the audit and has moved to protect the government's right to recover a potential overpayment. We have initiated reopening of Skagit Valley Hospital's Medicare cost report for the period ended 12/31/04 pending final disposition of the report and CMS instructions.

If you have any questions relating to this response, please contact myself at (701) 282-1415 or Ronald Knorr at (253) 437-5475.

Sincerely,

Michael Smith
Assistant Vice President, Medicare Part A Audit
Noridian Administrative Services, LLC

Cc: Jay Martinson, Executive VP and COO, NAS
Kathy Ellingson, Senior VP Medicare Operations, NAS
Ronald Knorr, Manager Provider Audit, NAS

Exhibit 1

Skip to main content

OFFICE OF
MANAGEMENT AND BUDGET

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

June 6, 2003

OMB BULLETIN NO. 03-04

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Revised Definitions of Metropolitan Statistical Areas, New Definitions of Micropolitan Statistical Areas and Combined Statistical Areas, and Guidance on Uses of the Statistical Definitions of These Areas

1. **Purpose**: This bulletin establishes revised definitions for the Nation's Metropolitan Statistical Areas and recognizes 49 new Metropolitan Statistical Areas. The bulletin also designates Metropolitan Divisions in those Metropolitan Statistical Areas that have a single core with a population of at least 2.5 million. In addition, the bulletin establishes definitions for two new sets of statistical areas: Micropolitan Statistical Areas and Combined Statistical Areas. New England City and Town Areas also are defined.

   The definitions of the statistical areas in the attached eight lists take effect immediately. The definitions reflect the Standards for Defining Metropolitan and Micropolitan Statistical Areas that the Office of Management and Budget (OMB) published on December 27, 2000, in the Federal Register (65 FR 82228 - 82238), and the application of those standards to Census 2000 population and journey-to-work data. This bulletin also provides guidance on the use of the definitions of these statistical areas.

2. **Background**: Pursuant to 44 U.S.C. 3504(e)(3) and 31 U.S.C. 1104(d) and Executive Order No. 10253 (June 11, 1951), the Office of Management and Budget (OMB) defines Metropolitan Statistical Areas, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas for use in Federal statistical activities. The attached lists represent the product of OMB's once-a-decade comprehensive review of statistical area standards and definitions. OMB issues periodic updates of the areas between decennial censuses based on Census Bureau data.

3. **Update of Statistical Areas:** This bulletin provides the definitions of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on December 27, 2000, in the Federal Register (65 FR 82228 - 82238) and Census 2000 data. The attachment to this bulletin provides the following lists of statistical areas that are recognized under the standards:

   List 1 is an alphabetical list by title of 935 Metropolitan Statistical Areas and Micropolitan Statistical Areas.

   List 2 provides titles, definitions, principal cities, and Metropolitan Divisions for 370 Metropolitan Statistical Areas. There are 49 new Metropolitan Statistical Areas that are identified in the list. There are 11 Metropolitan Statistical Areas that have a total of 29 Metropolitan Divisions.

   List 3 presents the titles, definitions, and principal cities for 565 Micropolitan Statistical Areas.

   List 4 identifies 116 Combined Statistical Areas and their 314 component Metropolitan and/or Micropolitan Statistical Areas.

   List 5 identifies in each state the Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, and Combined Statistical Areas.

   List 6 provides titles, definitions, principal cities, and New England City and Town Area Divisions for 42 New England City and Town Areas.

   List 7 provides titles and definitions for 9 Combined New England City and Town Areas and their 25 component New England City and Town Areas.

   List 8 identifies in each state the New England City and Town Areas, the New England City and Town Area Divisions, and the Combined New England City and Town Areas.

4. **Uses of Statistical Area Definitions:** All agencies that conduct statistical activities to collect and publish data for Metropolitan, Micropolitan, Combined Statistical Areas, and New England City and Town Areas should use the most recent definitions of these areas established by OMB.

   OMB establishes and maintains the definitions of Metropolitan and Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas solely for statistical purposes. This classification is intended to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. The Metropolitan and Micropolitan Statistical Area Standards do not equate to an urban-rural classification; many counties included in Metropolitan and Micropolitan Statistical Areas, and many other counties, contain both urban and rural

territory and populations.

In periodically reviewing and revising the definitions of these areas, OMB does not take into account or attempt to anticipate any nonstatistical uses that may be made of the definitions, nor will OMB modify the definitions to meet the requirements of any nonstatistical program. Thus, OMB cautions that Metropolitan Statistical Area and Micropolitan Statistical Area definitions should not be used to develop and implement Federal, state, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas.

OMB recognizes that some legislation specifies the use of Metropolitan Statistical Areas for program purposes, including the allocation of Federal funds, and will continue to work with the Congress to clarify the foundations of these definitions and the resultant, often unintended consequences of their use for nonstatistical purposes. In cases where there is no statutory requirement and an agency elects to use the Metropolitan, Micropolitan, or Combined Statistical Area definitions in nonstatistical programs, it is the sponsoring agency's responsibility to ensure that the definitions are appropriate for such use. When an agency is publishing for comment a proposed regulation that would use the definitions for a nonstatistical purpose, the agency should seek public comment on the proposed use.

An agency using the statistical definitions in a nonstatistical program may modify the definitions, but only for the purposes of that program. In such cases, any modifications should be clearly identified as deviations from the OMB statistical area definitions in order to avoid confusion with OMB's official definitions of Metropolitan, Micropolitan, and Combined Statistical Areas.

5. **Lists of Metropolitan, Micropolitan, and Combined Statistical Areas and New England City and Town Area Definitions:** This bulletin and its attachment that provides the eight lists of statistical areas are available electronically from the OMB web site at http://www.whitehouse.gov/OMB -- go to "Bulletins" or "Statistical Programs and Standards." The 2000 Standards for Defining Metropolitan and Micropolitan Statistical Areas are also available at http:/www./whitehouse.gov/OMB -- go to "Statistical Programs and Standards." (Information on historical definitions of Metropolitan Statistical Areas is available from the Census Bureau's web site at: http://www.census.gov/population/www/estimates/metroarea.html.)

6. **Inquiries:** Inquiries concerning the Metropolitan and Micropolitan Statistical Area Standards and the statistical uses of their definitions should be directed to Suzann Evinger (202-395-3093). Inquiries about uses of the statistical area definitions in program administration or regulation should be directed to the appropriate agency.

Mitchell E. Daniels, Jr.
Director

Attachment (141 pages, 659 kb)
-- Errata Sheet for the Lists of Areas in the Attachment to OMB Bulletin 03-04

www.omb.gov

OMB Bulletin No. 03-04
Attachment

METROPOLITAN STATISTICAL AREAS

MICROPOLITAN STATISTICAL AREAS

COMBINED STATISTICAL AREAS

NEW ENGLAND CITY AND TOWN AREAS

COMBINED NEW ENGLAND CITY AND TOWN AREAS

2003

Lists 1 through 8

Statistical and Science Policy Branch
Office of Information and Regulatory Affairs
Office of Management and Budget

Metropolitan Statistical Areas, Micropolitan Statistical Areas, Combined Statistical Areas, New England City and Town Areas, and Combined New England City and Town Areas -- 2003

1. Brief Overview of the Classification

The Office of Management and Budget (OMB) published the Standards for Defining Metropolitan and Micropolitan Statistical Areas in a *Federal Register* Notice (65 FR 82228 - 82238) on December 27, 2000. That Notice also provides information on the multi-year public review process that preceded the adoption of the standards, and an explanation of the key terms used in the standards. The 2000 standards replace and supersede the 1990 standards for defining Metropolitan Areas. OMB's 2000 standards provide for the identification of the following statistical areas in the United States and Puerto Rico:

- Metropolitan Statistical Areas
- Micropolitan Statistical Areas
- Metropolitan Divisions
- Combined Statistical Areas
- New England City and Town Areas
- New England City and Town Area Divisions
- Combined New England City and Town Areas

Metropolitan Statistical Areas have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan Statistical Areas – a new set of statistical areas – have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Metropolitan and Micropolitan Statistical Areas are defined in terms of whole counties (or equivalent entities), including in the six New England States. If the specified criteria are met, a Metropolitan Statistical Area containing a single core with a population of 2.5 million or more may be subdivided to form smaller groupings of counties referred to as Metropolitan Divisions.

The classification includes about 93 percent of the U.S. population – about 83 percent in metropolitan statistical areas and about 10 percent in micropolitan statistical areas. (Previously, the classification included about 80 percent of the U.S. population.) Of 3,142 counties in the United States (the 3,141 counties at the time of the 2000 decennial census plus Broomfield, Colorado, which became a county in November 2001), 1,090 will be in the 362 metropolitan statistical areas in the United States and 674 counties will be in micropolitan statistical areas (1,378 counties will remain outside the classification). (Previously, the classification included 847 metropolitan counties.)

In view of the importance of cities and town in New England, the 2000 standards also provide for a set of geographic areas that are defined using cities and towns in the six New England states. The New England City and Town Areas (NECTAs) are defined using the same criteria as Metropolitan and Micropolitan Statistical Areas and are identified as either metropolitan or micropolitan, based, respectively, on the presence of either an urbanized area of 50,000 or more population or an urban cluster of at least 10,000 but less than 50,000 population. If the specified criteria are met, a New England City and Town Area containing a single core with a population of at least 2.5 million may be subdivided to form smaller groupings of cities and towns referred to as New England City and Town Area Divisions.

If specified criteria are met, adjacent Metropolitan and Micropolitan Statistical Areas, in various combinations, may become the components of a new set of areas called Combined Statistical Areas. For instance, a Combined Statistical Area may comprise two or more Metropolitan Statistical Areas, a Metropolitan Statistical Area and a Micropolitan Statistical Area, two or more Micropolitan Statistical Areas, or multiple Metropolitan and Micropolitan Statistical Areas. The geographic components of

Combined New England City and Town Areas are individual metropolitan and micropolitan NECTAs, in various combinations. The areas that combine retain their own designations as Metropolitan or Micropolitan Statistical Areas (or NECTAs) within the larger Combined Statistical Area (or Combined NECTAs). Combinations for adjacent areas with an employment interchange of 25 or more are automatic. Combinations for adjacent areas with an employment interchange of at least 15 but less than 25 are based on local opinion as expressed through the Congressional delegations.

OMB's standards provide for the identification of one or more principal cities within each Metropolitan Statistical Area, Micropolitan Statistical Area, and NECTA. (The term "principal city" replaces "central city," the term used in previous standards.) Principal cities encompass both incorporated places and census designated places (CDPs). The decision to identify CDPs as principal cities represents a break with practice in previous standards that (with some exceptions) limited potential central city identification to incorporated places. In addition to identifying the more significant places in each Metropolitan and Micropolitan Statistical Area or NECTA in terms of population and employment, principal cities also are used in titling Metropolitan and Micropolitan Statistical Areas, Metropolitan Divisions, Combined Statistical Areas, NECTAs, NECTA Divisions, and Combined NECTAs.

The geographic components of Metropolitan and Micropolitan Statistical Areas and Metropolitan Divisions are counties and equivalent entities (boroughs and census areas in Alaska, parishes in Louisiana, municipios in Puerto Rico, and independent cities in Maryland, Missouri, Nevada, and Virginia). The counties and equivalent entities used in the definitions of the Metropolitan and Micropolitan Statistical Areas are those that were in existence as of January 1, 2000, with the exception of Broomfield County, Colorado.

The 2000 standards do not provide for the categorization of the areas based on total population comparable to Levels A – D under the 1990 standards.

This attachment includes the following eight lists that provide information on the statistical areas that are recognized under the 2000 standards using data from Census 2000:

- List 1 is an alphabetical list by title of 935 Metropolitan Statistical Areas and Micropolitan Statistical Areas.
- List 2 provides titles, definitions, principal cities, and Metropolitan Divisions for 370 Metropolitan Statistical Areas (362 in the United States and 8 in Puerto Rico). There are 49 new Metropolitan Statistical Areas that are identified in the list. There are 11 Metropolitan Statistical Areas that have a total of 29 Metropolitan Divisions.
- List 3 presents the titles, definitions, and principal cities for 565 Micropolitan Statistical Areas (560 in the United States and 5 in Puerto Rico).
- List 4 identifies 116 Combined Statistical Areas and their 315 component Metropolitan and/or Micropolitan Statistical Areas.
- List 5 identifies in each state the Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, and Combined Statistical Areas.
- List 6 provides titles, definitions, principal cities, and New England City and Town Area Divisions for 42 New England City and Town Areas.
- List 7 provides titles and definitions for 9 Combined New England City and Town Areas and their 25 component New England City and Town Areas.
- List 8 identifies in each state the New England City and Town Areas, the New England City and Town Area Divisions, and the Combined New England City and Town Areas.

2. Guidance on Presenting Data for Metropolitan and Micropolitan Statistical Areas, Metropolitan Divisions, Combined Statistical Areas, NECTAs, NECTA Divisions, and Combined NECTAs

Metropolitan and Micropolitan Statistical Areas represent the basic set of county based areas defined under this classification, and they are defined using the same criteria. If specified criteria are met, Metropolitan Divisions are defined within Metropolitan Statistical Areas that have a single core with a population of at least 2.5 million. Not all Metropolitan Statistical Areas with urbanized areas of this size will contain Metropolitan Divisions. Because Metropolitan Divisions represent subdivisions of (larger) Metropolitan Statistical Areas, it is not appropriate to rank or compare Metropolitan Divisions with Metropolitan and Micropolitan Statistical Areas. It would be appropriate to rank and compare Metropolitan Divisions.

Similarly, it is not appropriate to rank or compare NECTA Divisions with Metropolitan and Micropolitan NECTAs, but it is appropriate to rank and compare NECTA Divisions.

Because Combined Statistical Areas represent groupings of Metropolitan and Micropolitan Statistical Areas (in any combination), they should not be ranked or compared with individual Metropolitan and Micropolitan Statistical Areas.

Because Combined New England City and Town Areas (NECTAs) represent groupings of Metropolitan and Micropolitan NECTAs (in any combination), they should not be ranked or compared with individual Metropolitan and Micropolitan NECTAs.

3. Codes for Metropolitan and Micropolitan Statistical Areas, Metropolitan Divisions, Combined Statistical Areas, New England City and Town Areas (NECTAs), NECTA Divisions, and Combined NECTAs

Codes for Metropolitan and Micropolitan Statistical Areas, Metropolitan Divisions, NECTAs, and NECTA Divisions will be 5 digits in length. This replaces the 4-digit code previously used. Codes for Metropolitan and Micropolitan Statistical Areas and Metropolitan Divisions fall within the 10000 to 59999 range and are assigned in alphabetical order by area title. Metropolitan Divisions are distinguished by a 5-digit code ending in "4."

NECTA and NECTA Division codes fall within the 70000 to 79999 range and are assigned in alphabetical order by area title. NECTA Divisions will be distinguished by a 5-digit code ending in "4."

Combined Statistical Area and Combined NECTA codes will be 3 digits in length. Combined Statistical Area codes will fall within the 100 to 599 range. Combined NECTA codes will fall within the 700 to 799 range.

List 1

Metropolitan and Micropolitan Statistical Areas

This list provides an alphabetical list by title of all 935 Metropolitan and Micropolitan Statistical Areas. The code for each Metropolitan and Micropolitan Statistical Area also is provided. The 49 new Metropolitan Statistical Areas are shown in bold print. All Micropolitan Statistical Areas are new.

Code	Metropolitan or Micropolitan Statistical Area Title
10020	Abbeville, LA Micropolitan Statistical Area
10100	Aberdeen, SD Micropolitan Statistical Area
10140	Aberdeen, WA Micropolitan Statistical Area
10180	Abilene, TX Metropolitan Statistical Area
10220	Ada, OK Micropolitan Statistical Area
10260	Adjuntas, PR Micropolitan Statistical Area
10300	Adrian, MI Micropolitan Statistical Area
10380	Aguadilla-Isabela-San Sebastián, PR Metropolitan Statistical Area
10420	Akron, OH Metropolitan Statistical Area
10460	Alamogordo, NM Micropolitan Statistical Area
10500	Albany, GA Metropolitan Statistical Area
10540	Albany-Lebanon, OR Micropolitan Statistical Area
10580	Albany-Schenectady-Troy, NY Metropolitan Statistical Area
10620	Albemarle, NC Micropolitan Statistical Area
10660	Albert Lea, MN Micropolitan Statistical Area
10700	Albertville, AL Micropolitan Statistical Area
10740	Albuquerque, NM Metropolitan Statistical Area
10780	Alexandria, LA Metropolitan Statistical Area
10820	Alexandria, MN Micropolitan Statistical Area
10860	Alice, TX Micropolitan Statistical Area
10880	Allegan, MI Micropolitan Statistical Area
10900	Allentown-Bethlehem-Easton, PA-NJ Metropolitan Statistical Area
10940	Alma, MI Micropolitan Statistical Area
10980	Alpena, MI Micropolitan Statistical Area
11020	Altoona, PA Metropolitan Statistical Area
11060	Altus, OK Micropolitan Statistical Area
11100	Amarillo, TX Metropolitan Statistical Area
11140	Americus, GA Micropolitan Statistical Area
11180	**Ames, IA Metropolitan Statistical Area**
11220	Amsterdam, NY Micropolitan Statistical Area
11260	Anchorage, AK Metropolitan Statistical Area
11300	Anderson, IN Metropolitan Statistical Area
11340	Anderson, SC Metropolitan Statistical Area
11380	Andrews, TX Micropolitan Statistical Area
11420	Angola, IN Micropolitan Statistical Area
11460	Ann Arbor, MI Metropolitan Statistical Area
11500	Anniston-Oxford, AL Metropolitan Statistical Area
11540	Appleton, WI Metropolitan Statistical Area
11580	Arcadia, FL Micropolitan Statistical Area
11620	Ardmore, OK Micropolitan Statistical Area
11660	Arkadelphia, AR Micropolitan Statistical Area
11700	Asheville, NC Metropolitan Statistical Area
11740	Ashland, OH Micropolitan Statistical Area

33140	**Michigan City-La Porte, IN Metropolitan Statistical Area**
33180	Middlesborough, KY Micropolitan Statistical Area
33220	Midland, MI Micropolitan Statistical Area
33260	Midland, TX Metropolitan Statistical Area
33300	Milledgeville, GA Micropolitan Statistical Area
33340	Milwaukee-Waukesha-West Allis, WI Metropolitan Statistical Area
33380	Minden, LA Micropolitan Statistical Area
33420	Mineral Wells, TX Micropolitan Statistical Area
33460	Minneapolis-St. Paul-Bloomington, MN-WI Metropolitan Statistical Area
33500	Minot, ND Micropolitan Statistical Area
33540	Missoula, MT Metropolitan Statistical Area
33580	Mitchell, SD Micropolitan Statistical Area
33620	Moberly, MO Micropolitan Statistical Area
33660	Mobile, AL Metropolitan Statistical Area
33700	Modesto, CA Metropolitan Statistical Area
33740	Monroe, LA Metropolitan Statistical Area
33780	**Monroe, MI Metropolitan Statistical Area**
33820	Monroe, WI Micropolitan Statistical Area
33860	Montgomery, AL Metropolitan Statistical Area
33940	Montrose, CO Micropolitan Statistical Area
33980	Morehead City, NC Micropolitan Statistical Area
34020	Morgan City, LA Micropolitan Statistical Area
34060	**Morgantown, WV Metropolitan Statistical Area**
34100	**Morristown, TN Metropolitan Statistical Area**
34140	Moscow, ID Micropolitan Statistical Area
34180	Moses Lake, WA Micropolitan Statistical Area
34220	Moultrie, GA Micropolitan Statistical Area
34260	Mountain Home, AR Micropolitan Statistical Area
34300	Mountain Home, ID Micropolitan Statistical Area
34340	Mount Airy, NC Micropolitan Statistical Area
34380	Mount Pleasant, MI Micropolitan Statistical Area
34420	Mount Pleasant, TX Micropolitan Statistical Area
34460	Mount Sterling, KY Micropolitan Statistical Area
34500	Mount Vernon, IL Micropolitan Statistical Area
34540	Mount Vernon, OH Micropolitan Statistical Area
* **34580**	**Mount Vernon-Anacortes, WA Metropolitan Statistical Area**
34620	Muncie, IN Metropolitan Statistical Area
34660	Murray, KY Micropolitan Statistical Area
34700	Muscatine, IA Micropolitan Statistical Area
34740	Muskegon-Norton Shores, MI Metropolitan Statistical Area
34780	Muskogee, OK Micropolitan Statistical Area
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Metropolitan Statistical Area
34860	Nacogdoches, TX Micropolitan Statistical Area
34900	Napa, CA Metropolitan Statistical Area
34940	Naples-Marco Island, FL Metropolitan Statistical Area
34980	Nashville-Davidson—Murfreesboro, TN Metropolitan Statistical Area
35020	Natchez, MS-LA Micropolitan Statistical Area
35060	Natchitoches, LA Micropolitan Statistical Area
35100	New Bern, NC Micropolitan Statistical Area
35140	Newberry, SC Micropolitan Statistical Area
35220	New Castle, IN Micropolitan Statistical Area
35260	New Castle, PA Micropolitan Statistical Area
35300	New Haven-Milford, CT Metropolitan Statistical Area
35340	New Iberia, LA Micropolitan Statistical Area
35380	New Orleans-Metairie-Kenner, LA Metropolitan Statistical Area
35420	New Philadelphia-Dover, OH Micropolitan Statistical Area

33260 Midland, TX Metropolitan Statistical Area
Principal City: Midland
Midland County

33340 Milwaukee-Waukesha-West Allis, WI Metropolitan Statistical Area
Principal Cities: Milwaukee, Waukesha, West Allis
Milwaukee County, Ozaukee County, Washington County, Waukesha County

33460 Minneapolis-St. Paul-Bloomington, MN-WI Metropolitan Statistical Area
Principal Cities: Minneapolis, MN; St. Paul, MN; Bloomington, MN; Plymouth, MN; Eagan, MN; Eden Prairie, MN; Minnetonka, MN
Anoka County, MN; Carver County, MN; Chisago County, MN; Dakota County, MN; Hennepin County, MN; Isanti County, MN; Ramsey County, MN; Scott County, MN; Sherburne County, MN; Washington County, MN; Wright County, MN; Pierce County, WI; St. Croix County, WI

33540 Missoula, MT Metropolitan Statistical Area
Principal City: Missoula
Missoula County

33660 Mobile, AL Metropolitan Statistical Area
Principal City: Mobile
Mobile County

33700 Modesto, CA Metropolitan Statistical Area
Principal City: Modesto
Stanislaus County

33740 Monroe, LA Metropolitan Statistical Area
Principal City: Monroe
Ouachita Parish, Union Parish

33780 Monroe, MI Metropolitan Statistical Area (New)
Principal City: Monroe
Monroe County

33860 Montgomery, AL Metropolitan Statistical Area
Principal City: Montgomery
Autauga County, Elmore County, Lowndes County, Montgomery County

34060 Morgantown, WV Metropolitan Statistical Area (New)
Principal City: Morgantown
Monongalia County, Preston County

34100 Morristown, TN Metropolitan Statistical Area (New)
Principal City: Morristown
Grainger County, Hamblen County, Jefferson County

* 34580 Mount Vernon-Anacortes, WA Metropolitan Statistical Area (New)
Principal Cities: Mount Vernon, Anacortes
Skagit County

34620 Muncie, IN Metropolitan Statistical Area
Principal City: Muncie
Delaware County

Virginia		
13980	Blacksburg-Christiansburg-Radford, VA	Metropolitan Statistical Area
14140	Bluefield, WV-VA (part)	Micropolitan Statistical Area
14980	Bristol, VA	Metropolitan Statistical Area
16820	Charlottesville, VA	Metropolitan Statistical Area
19260	Danville, VA	Metropolitan Statistical Area
25500	Harrisonburg, VA	Metropolitan Statistical Area
304	Johnson City-Kingsport-Bristol, TN-VA (part)	Combined Statistical Area
28700	Kingsport-Bristol, TN-VA (part)	Metropolitan Statistical Area
31340	Lynchburg, VA	Metropolitan Statistical Area
32300	Martinsville, VA	Micropolitan Statistical Area
40060	Richmond, VA	Metropolitan Statistical Area
40220	Roanoke, VA	Metropolitan Statistical Area
44420	Staunton-Waynesboro, VA	Micropolitan Statistical Area
47260	Virginia Beach-Norfolk-Newport News, VA-NC (part)	Metropolitan Statistical Area
47900	Washington-Arlington-Alexandria, DC-VA-MD-WV (part)	Metropolitan Statistical Area
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV (part)	Metropolitan Division
548	Washington-Baltimore-Northern Virginia, DC-MD-VA-WV (part)	Combined Statistical Area
49020	Winchester, VA-WV (part)	Metropolitan Statistical Area
Washington		
10140	Aberdeen, WA	Micropolitan Statistical Area
13380	Bellingham, WA	Metropolitan Statistical Area
14740	Bremerton-Silverdale, WA	Metropolitan Statistical Area
16500	Centralia, WA	Micropolitan Statistical Area
21260	Ellensburg, WA	Micropolitan Statistical Area
28420	Kennewick-Richland-Pasco, WA	Metropolitan Statistical Area
30300	Lewiston, ID-WA (part)	Metropolitan Statistical Area
31020	Longview-Kelso, WA	Metropolitan Statistical Area
34180	Moses Lake, WA	Micropolitan Statistical Area
34580	Mount Vernon-Anacortes, WA	Metropolitan Statistical Area
36020	Oak Harbor, WA	Micropolitan Statistical Area
36500	Olympia, WA	Metropolitan Statistical Area
38820	Port Angeles, WA	Micropolitan Statistical Area
38900	Portland-Vancouver-Beaverton, OR-WA (part)	Metropolitan Statistical Area
39420	Pullman, WA	Micropolitan Statistical Area
42660	Seattle-Tacoma-Bellevue, WA	Metropolitan Statistical Area
42644	Seattle-Bellevue-Everett, WA	Metropolitan Division
45104	Tacoma, WA	Metropolitan Division
500	Seattle-Tacoma-Olympia, WA	Combined Statistical Area
43220	Shelton, WA	Micropolitan Statistical Area
44060	Spokane, WA	Metropolitan Statistical Area
47460	Walla Walla, WA	Micropolitan Statistical Area
48300	Wenatchee, WA	Metropolitan Statistical Area
49420	Yakima, WA	Metropolitan Statistical Area
West Virginia		
13220	Beckley, WV	Micropolitan Statistical Area
138	Beckley-Oak Hill, WV	Combined Statistical Area
14140	Bluefield, WV-VA (part)	Micropolitan Statistical Area
16620	Charleston, WV	Metropolitan Statistical Area
17220	Clarksburg, WV	Micropolitan Statistical Area
19060	Cumberland, MD-WV (part)	Metropolitan Statistical Area
21900	Fairmont, WV	Micropolitan Statistical Area
242	Fairmont-Clarksburg, WV	Combined Statistical Area
25180	Hagerstown-Martinsburg, MD-WV (part)	Metropolitan Statistical Area
26580	Huntington-Ashland, WV-KY-OH (part)	Metropolitan Statistical Area
34060	Morgantown, WV	Metropolitan Statistical Area
36060	Oak Hill, WV	Micropolitan Statistical Area
37620	Parkersburg-Marietta, WV-OH (part)	Metropolitan Statistical Area
38580	Point Pleasant, WV-OH (part)	Micropolitan Statistical Area