§ 455.202 Limitation on contractor liability.

(a) A program contractor, a person, or an entity employed by, or having a fiduciary relationship with, or who furnishes professional services to a program contractor will not be held to have violated any criminal law and will not be held liable in any civil action, under any law of the United States or of any State (or political subdivision thereof), by reason of the performance of any duty, function, or activity required or authorized under this subpart or under a valid contract entered into under this subpart, provided due care was exercised in that performance and the contractor has a contract with CMS under this subpart.

(b) CMS pays a contractor, a person, or an entity described in paragraph (a) of this section, or anyone who furnishes legal counsel or services to a contractor or person, a sum equal to the reasonable amount of the expenses, as determined by CMS, incurred in connection with the defense of a suit, action, or proceeding, if the following conditions are met:

(1) The suit, action, or proceeding was brought against the contractor, person or entity by a third party and relates to the contractor's, person's or entity's performance of any duty, function, or activity under a contract entered into with CMS under this subpart.

(2) The funds are available.

(3) The expenses are otherwise allowable under the terms of the contract.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 27, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 9, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. E7–23217 Filed 11–29–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 484

[CMS–1541–CN2]

RIN 0938–AO32

Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Corrections

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

ACTION: Final rule with comment period; correction notice.

SUMMARY: This document corrects typographical and technical errors that appeared in the August 29, 2007 **Federal Register**, entitled ''Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008.''

EFFECTIVE DATE: This correction notice is effective January 1, 2008.

FOR FURTHER INFORMATION CONTACT: Sharon Ventura, (410) 786–1985.

SUPPLEMENTARY INFORMATION:

I. Background

FR Doc. 07–4184 of August 29, 2007 (72 FR 49762) contained several typographical and technical errors that this notice serves to identify and correct.

II. Summary of Errors

On page 49773, in the second paragraph of the third column, the reference to the McCall report is incomplete. We are correcting the error by providing the complete reference.

In the first column on page 49774, we are clarifying and correcting an erroneous reference to certain V codes in our response to a comment.

In the first full paragraph of the first column on page 49775, we inadvertently imply that a table is included in the August 29, 2007 final rule. However, the referenced table is found in the May 4, 2007 proposed rule. We are correcting this by referencing the proposed rule.

On page 49780, the example in column 1 is revised to reflect the updates made to Table 2A in the final rule with comment period.

On page 49789, in the fourth column of Table 2B, the Short Descriptions of ICD–9–CM codes 161, 162, 163, 164, and 165 incorrectly contain asterisks.

On page 49793, in Table 2B, the ICD–9–CM code 321.8, we inadvertently did not include an 'M' next to it under the column titled, ''Manifestation codes'' in order to properly identify it as a manifestation code.

To more accurately reflect ICD–9–CM coding terminology, we are correcting the Diagnostic Category titles for ICD–9–CM codes V55.0 and V55.5 on page 49817 of Table 2B. In addition we are correcting the Diagnostic Category titles for ICD–9–CM codes V55.5, V55.0, and V55.6 and the Short Descriptions for ICD–9–CM codes V55.5 and V55.0 on page 49855 of Table 10B.

During production of Table 4 on pages 49826 through 49827, the decimal amounts were incorrectly rounded when computing the scaled coefficients. We are revising Table 4 to reflect the corrected rounded amounts.

The average cost amounts in Table 5 on pages 49828 through 49832 were also rounded incorrectly. Therefore, we are revising Table 5 to reflect the average cost of each case-mix group. There are no changes to the relative weights in Table 5.

On page 49833, second paragraph, a negative sign was inadvertently placed before ''8.7 percent.''

On page 49844, we incorrectly stated the acronym for the Health Insurance Prospective Payment System (HIPPS) code. The correct acronym is HIPPS. We are correcting the acronym to HIPPS wherever it appears.

On page 49853 the description for Item #5 for selected skin conditions in Table 10A incorrectly includes the words ''or other''. Also on page 49853, in the first column of the Note section for Table 10A, we are correcting punctuation errors. Therefore, in the second column of the Note section for Table 10A, the reference to Table 12B should refer to Table 10B. Lastly, we inadvertently excluded a footnote to Table 10A that clarified how points are awarded for ulcer related conditions.

On page 49854, we are correcting the short description of ICD–9–CM code 250.8x & 707.10–707.9 from ''(PRIMARY OR FIRST OTHER DIAGNOSIS = 250.8x AND PRIMARY OR FIRST OTHER DIAGNOSIS = 707.10–707.9).'' to ''(PRIMARY DIAGNOSIS = 250.8x AND OTHER DIAGNOSIS = 707.10–707.9).''

On page 49855, we inadvertently omitted ICD–9–CM code 948 from Table 10B under the traumatic wounds, burns and post-operative complications category. We are adding code 948 and its short description to Table 10B.

Table 12 and 14 contain several typographical errors. The CY 2007 per-visit amount for the speech-language pathology discipline found in the second column of both Table 12 on page

49868 and in Table 14 on page 49873 should be $121.32, and the speech-language pathology per-visit amount for CY 2008 in column 5 of Table 12 should be $124.65. Similarly, on page 49873, the speech-language pathology per-visit amount for CY 2008 in column 5 of Table 14 should be $122.23.

We are correcting errors in the outlier example that begins on page 49870 and continues on page 49871 as well as providing clarifying narrative language. Due to corrections being made to the outlier example, noted below, the utilization used in the outlier example that was published in the final rule would not allow the episode to qualify for an outlier payment. Consequently, we are increasing the number of skilled nursing and home health aide visits in the corrected outlier example of this correction notice.

In addition, in Step 2, on page 49871, in the calculation of the total wage-adjusted fixed dollar loss amount, the NRS amount was inadvertently included as part of the calculation. We are removing the language in Step 2 of the outlier example that incorrectly includes the NRS amount, in order to reflect the correct outlier policy.

In Step 3 of the outlier example, near the bottom of the second column and the top of the third column on page 49871, we incorrectly refer to physical therapy visits as home health aide visits in three instances.

In Step 4 of the outlier example, on page 49871, we incorrectly calculated the costs absorbed by the Home Health Agencies (HHAs) in excess of the outlier threshold by subtracting only the episode payment from the HHA's imputed costs. The sum of the episode payment and the fixed dollar loss amount, which together make up the outlier threshold, should be subtracted from the imputed costs. (This is reflected in the corrected Step 4 of the outlier example in Section III Correction of Errors).

On page 49877, in Table 15 under the impacts by ''Type of Facility'', we are correcting a typographical error in the group name for the subtotal for voluntary non-profit HHAs.

During our calculation of the hospital wage index, wage data from two inpatient hospital providers that belong in the Hartford-West Hartford-East Hartford, CT core-based statistical area (CBSA) were inadvertently included in rural Connecticut. Accordingly, in Addendum A, we are revising the wage index value for CBSA Code 07 (rural Connecticut) from 1.1283 to 1.1711. We are also correcting the wage index value in Addendum C as well as correcting the percentage change from CY 2007 to CY 2008 for rural Connecticut to 0.02 percent.

In Addendum B, we are revising the wage index value for CBSA Code 25540 (Hartford-West Hartford-East Hartford, CT) from 1.0937 to 1.0930. We are also correcting the wage index value in Addendum C as well as correcting the percentage change from CY 2007 to CY 2008 for CBSA 25540 to 0.33 percent.

During our calculation of the hospital wage index, wage data from one IPPS hospital was incorrectly assigned to CBSA 16180 (Carson City, NV) and should have been assigned to CBSA 39900 (Reno-Sparks, NV). Accordingly, in Addendum B, we are revising the wage index values for CBSA Code 16180 (Carson City, NV) from 0.9353 to 1.0003 and for CBSA Code 39900 (Reno-Sparks, NV) from 1.0959 to 1.0715. We are also correcting these two wage index errors in Addendum C as well as correcting the percentage change from CY 2007 to CY 2008 for CBSA 16180 and CBSA 39900 to −0.22 percent and −10.43 percent respectively.

In addition, in the footnote of Addendum A, at the end of the second sentence, we are correcting the CY that was referenced as CY 2007, instead of CY 2008. Additionally, we inadvertently left out the last two sentences which more fully describe the wage index values for Massachusetts and Puerto Rico and are correcting the footnote by adding those sentences at the end of the footnote at the bottom of Addendum A.

In Addendum B, on page 49901, the reference to the footnote for CBSA 25980 was incorrectly labeled as footnote ''2'', when there is only one footnote for Addendum B. Footnote 2 on page 49932 is also incorrectly labeled. Consequently, the reference to the footnote for CBSA 25980 and the actual footnote should be ''1''.

III. Correction of Errors

In FR Doc. 07–4184 of August 29, 2007 (72 FR 49762), make the following corrections:

1. On page 49773, in the third column, in the second paragraph, in line 6, replace ''(McCall *et al.*, 2003)'' with ''(N McCall *et al.*, ''Utilization of Home Health Services before and after the Balanced Budget Act of 1997: What Were the Initial Effects?'' Health Services Research, Feb. 2003:85–106.)''.

2. On page 49774, in the first column, in the fifth full paragraph, in line 8, revise ''However, we have tested the non-routine supplies for stoma conditions for which we have added appropriate ''status (V44) V-codes'' and ''attention (V55) V-codes'' to the model.'' to read ''However, we have tested both the case-mix model and the non-routine supplies model for stoma conditions, and as a result we have added appropriate ''attention to'' V-codes (selected codes within V55) to the scoring systems''.

3. On page 49775, in the first column, in the first full paragraph, in lines 13 and 14, revise ''(please see Table 2A at the end of section III.B.5)'' to read ''(please see Table 2A in the May 4, 2007 HH PPS proposed rule)''.

4. On page 49780, in the first column, in line 6, revise ''Items 16 and 17'' to read ''Items 15, 16, and 17''. Also, in the first column of page 49780, in line 7, revise ''both'' to read ''all three''.

5. On page 49789, in Table 2B, in the fourth column, in lines 3 through 7, remove the asterisk at the end of each Short Description of ICD–9–CM codes 161, 162, 163, 164, and 165.

6. On page 49793, in the third column of Table 2B, in line 6 from the bottom, insert an ''M'' next to the ICD–9–CM code ''321.8''.

7. On page 49817, in the first column of Table 2B, ''Tracheostomy care'' is corrected to read ''Tracheostomy''. Similarly, ''Urostomy/Cystostomy care'' is corrected to read ''Urostomy/Cystostomy''.

8. On pages 49826 and 49827, Table 4 is corrected to read as follows:

TABLE 4.—REGRESSION COEFFICIENTS FOR CALCULATING CASE-MIX RELATIVE WEIGHTS

Intercept (constant for all case mix groups)	$1,322.92
1st and 2nd Episodes, 0 to 13 Therapy Visits	
C2	342.36
C3	722.64
F2	201.15
F3	391.18
S2 (6 therapy visits)	608.45

TABLE 4.—REGRESSION COEFFICIENTS FOR CALCULATING CASE-MIX RELATIVE WEIGHTS—Continued

S3 (7–9 therapy visits)	1,083.40
S4 (10 therapy visits)	1,570.38
S5 (11–13 therapy visits)	1,970.41
1st and 2nd Episodes, 14 to 19 Therapy Visits	
Constant	2,336.39
C2	569.40
C3	1,227.33
F2	264.04
F3	429.54
S2 (16–17 therapy visits)	353.49
S3 (18–19 therapy visits)	664.75
3rd+ Episodes, 0 to 13 Therapy Visits	
Constant	162.55
C2	131.91
C3	648.40
F2	304.00
F3	592.10
S2 (6 therapy visits)	794.16
S3 (7–9 therapy visits)	1,253.67
S4 (10 therapy visits)	1,755.87
S5 (11–13 therapy visits)	2,152.49
3rd+ Episodes, 14 to 19 Therapy Visits Constant	
Constant	2,656.96
C2	623.43
C3	1,350.61
F2	297.18
F3	681.32
S2 (16–17 therapy visits)	263.13
S3 (18–19 therapy visits)	617.98
All Episodes, 20+ Therapy Visits Constant	
Constant	4,465.27
C2	485.17
C3	1,212.35
F2	430.23
F3	916.53

Note: Regression coefficients were scaled by a multiplier representing the ratio of the HH PS base payment level to the Abt Associates average resource cost level.

9. On pages 49828 through 49832, Table 5 is corrected to read as follows:

TABLE 5.—CASE MIX GROUPS, AVERAGE COST, AND CASE MIX WEIGHT

Severity Level for Each Dimension				
Clinical	Functional	Service utilization	Average cost	Case mix weight
1st and 2nd Episodes, 0 to 13 Therapy Visits				
C1	F1	S1	$1,322.92	0.5827
C1	F1	S2	1,931.36	0.8507
C1	F1	S3	2,406.31	1.0599
C1	F1	S4	2,893.30	1.2744
C1	F1	S5	3,293.33	1.4506
C1	F2	S1	1,524.07	0.6713
C1	F2	S2	2,132.51	0.9393
C1	F2	S3	2,607.46	1.1485
C1	F2	S4	3,094.45	1.3630
C1	F2	S5	3,494.48	1.5392
C1	F3	S1	1,714.09	0.7550
C1	F3	S2	2,322.54	1.0230
C1	F3	S3	2,797.49	1.2322
C1	F3	S4	3,284.47	1.4467
C1	F3	S5	3,684.50	1.6229

TABLE 5.—CASE MIX GROUPS, AVERAGE COST, AND CASE MIX WEIGHT—Continued

Severity Level for Each Dimension				
Clinical	Functional	Service utilization	Average cost	Case mix weight
C2	F1	S1	1,665.28	0.7335
C2	F1	S2	2,273.73	1.0015
C2	F1	S3	2,748.68	1.2107
C2	F1	S4	3,235.66	1.4252
C2	F1	S5	3,635.69	1.6014
C2	F2	S1	1,866.43	0.8221
C2	F2	S2	2,474.88	1.0901
C2	F2	S3	2,949.83	1.2993
C2	F2	S4	3,436.81	1.5138
C2	F2	S5	3,836.84	1.6900
C2	F3	S1	2,056.46	0.9058
C2	F3	S2	2,664.90	1.1738
C2	F3	S3	3,139.85	1.3830
C2	F3	S4	3,626.84	1.5975
C2	F3	S5	4,026.87	1.7737
C3	F1	S1	2,045.56	0.9010
C3	F1	S2	2,654.23	1.1691
C3	F1	S3	3,129.18	1.3783
C3	F1	S4	3,615.94	1.5927
C3	F1	S5	4,016.20	1.7690
C3	F2	S1	2,246.71	0.9896
C3	F2	S2	2,855.38	1.2577
C3	F2	S3	3,330.33	1.4669
C3	F2	S4	3,817.09	1.6813
C3	F2	S5	4,217.35	1.8576
C3	F3	S1	2,436.73	1.0733
C3	F3	S2	3,045.41	1.3414
C3	F3	S3	3,520.36	1.5506
C3	F3	S4	4,007.11	1.7650
C3	F3	S5	4,407.37	1.9413
1st and 2nd Episodes, 14 to 19 Therapy Visits				
C1	F1	S1	3,659.30	1.6118
C1	F1	S2	4,012.79	1.7675
C1	F1	S3	4,324.05	1.9046
C1	F2	S1	3,923.34	1.7281
C1	F2	S2	4,276.60	1.8837
C1	F2	S3	4,587.86	2.0208
C1	F3	S1	4,088.85	1.8010
C1	F3	S2	4,442.11	1.9566
C1	F3	S3	4,753.37	2.0937
C2	F1	S1	4,228.70	1.8626
C2	F1	S2	4,582.19	2.0183
C2	F1	S3	4,893.45	2.1554
C2	F2	S1	4,492.74	1.9789
C2	F2	S2	4,846.00	2.1345
C2	F2	S3	5,157.26	2.2716
C2	F3	S1	4,658.24	2.0518
C2	F3	S2	5,011.50	2.2074
C2	F3	S3	5,322.77	2.3445
C3	F1	S1	4,886.64	2.1524
C3	F1	S2	5,240.13	2.3081
C3	F1	S3	5,551.16	2.4451
C3	F2	S1	5,150.45	2.2686
C3	F2	S2	5,503.94	2.4243
C3	F2	S3	5,814.97	2.5613
C3	F3	S1	5,315.95	2.3415
C3	F3	S2	5,669.44	2.4972
C3	F3	S3	5,980.48	2.6342
3rd+ Episodes, 0 to 13 Therapy Visits				
C1	F1	S1	1,485.47	0.6543
C1	F1	S2	2,279.63	1.0041
C1	F1	S3	2,739.14	1.2065
C1	F1	S4	3,241.34	1.4277
C1	F1	S5	3,637.96	1.6024
C1	F2	S1	1,789.47	0.7882
C1	F2	S2	2,583.62	1.1380

TABLE 5.—CASE MIX GROUPS, AVERAGE COST, AND CASE MIX WEIGHT—Continued

Severity Level for Each Dimension				
Clinical	Functional	Service utilization	Average cost	Case mix weight
C1	F2	S3	3,043.36	1.3405
C1	F2	S4	3,545.56	1.5617
C1	F2	S5	3,942.18	1.7364
C1	F3	S1	2,077.57	0.9151
C1	F3	S2	2,871.73	1.2649
C1	F3	S3	3,331.47	1.4674
C1	F3	S4	3,833.66	1.6886
C1	F3	S5	4,230.06	1.8632
C2	F1	S1	1,617.38	0.7124
C2	F1	S2	2,411.53	1.0622
C2	F1	S3	2,871.05	1.2646
C2	F1	S4	3,373.24	1.4858
C2	F1	S5	3,769.87	1.6605
C2	F2	S1	1,921.37	0.8463
C2	F2	S2	2,715.76	1.1962
C2	F2	S3	3,175.27	1.3986
C2	F2	S4	3,677.46	1.6198
C2	F2	S5	4,074.09	1.7945
C2	F3	S1	2,209.48	0.9732
C2	F3	S2	3,003.63	1.3230
C2	F3	S3	3,463.37	1.5255
C2	F3	S4	3,965.57	1.7467
C2	F3	S5	4,361.97	1.9213
C3	F1	S1	2,133.87	0.9399
C3	F1	S2	2,928.03	1.2897
C3	F1	S3	3,387.77	1.4922
C3	F1	S4	3,889.97	1.7134
C3	F1	S5	4,286.36	1.8880
C3	F2	S1	2,437.87	1.0738
C3	F2	S2	3,232.25	1.4237
C3	F2	S3	3,691.77	1.6261
C3	F2	S4	4,193.96	1.8473
C3	F2	S5	4,590.59	2.0220
C3	F3	S1	2,725.97	1.2007
C3	F3	S2	3,520.36	1.5506
C3	F3	S3	3,979.87	1.7530
C3	F3	S4	4,482.07	1.9742
C3	F3	S5	4,878.69	2.1489
3rd+ Episodes, 14 to 19 Therapy Visits				
C1	F1	S1	3,979.87	1.7530
C1	F1	S2	4,243.00	1.8689
C1	F1	S3	4,597.85	2.0252
C1	F2	S1	4,277.06	1.8839
C1	F2	S2	4,540.19	1.9998
C1	F2	S3	4,894.81	2.1560
C1	F3	S1	4,661.19	2.0531
C1	F3	S2	4,924.32	2.1690
C1	F3	S3	5,278.95	2.3252
C2	F1	S1	4,603.30	2.0276
C2	F1	S2	4,866.43	2.1435
C2	F1	S3	5,221.28	2.2998
C2	F2	S1	4,900.49	2.1585
C2	F2	S2	5,163.62	2.2744
C2	F2	S3	5,518.24	2.4306
C2	F3	S1	5,284.62	2.3277
C2	F3	S2	5,547.75	2.4436
C2	F3	S3	5,902.38	2.5998
C3	F1	S1	5,330.48	2.3479
C3	F1	S2	5,593.39	2.4637
C3	F1	S3	5,948.24	2.6200
C3	F2	S1	5,627.44	2.4787
C3	F2	S2	5,890.57	2.5946
C3	F2	S3	6,245.42	2.7509
C3	F3	S1	6,011.58	2.6479
C3	F3	S2	6,274.71	2.7638
C3	F3	S3	6,629.56	2.9201

TABLE 5.—CASE MIX GROUPS, AVERAGE COST, AND CASE MIX WEIGHT—Continued

Severity Level for Each Dimension				
Clinical	Functional	Service utilization	Average cost	Case mix weight
All Episodes, 20+ Therapy Visits				
C1	F1	S1	5,788.18	2.5495
C1	F2	S1	6,218.41	2.7390
C1	F3	S1	6,704.71	2.9532
C2	F1	S1	6,273.35	2.7632
C2	F2	S1	6,703.57	2.9527
C2	F3	S1	7,189.88	3.1669
C3	F1	S1	7,000.53	3.0835
C3	F2	S1	7,430.76	3.2730
C3	F3	S1	7,917.06	3.4872

10. On page 49833, in the first column, in the second paragraph, in line 18 from the bottom, remove the ''−'' (minus sign) in front of ''8.7 percent''.

11. On page 49844, in the first column, in the first full paragraph, in line 8, ''HIHH PPS'' is corrected to read ''HIPPS''. Also, on page 49844, in the second column, ''HIHH PPS'' is corrected to read ''HIPPS'' in lines 2, 4, and 14.

12. On page 49853, in the second column of Table 10A, in line 5, the description for Item #5 ''Primary or other diagnosis=Diabetic ulcers'' is corrected to read ''Primary diagnosis = Diabetic ulcers''. Also in Table 10A, add ''[*]'' (an asterisk enclosed in brackets) at the end of lines 5 and 10. Also on page 49853, in the first column of the ''Note'' for Table 10A, in line 1, replace the '','' after the word ''additive'' with a '';''. Also in line 1, add a '','' after the word ''however''.

In the second column of the ''Note'' for Table 10A, in line 2, ''Table 12b'' is corrected to read ''Table 10B''. Lastly, on page 49853, add the following footnote, referenced by the ''[*]'' at the end of lines 5 and 10 in Table 10A, to the end of the current Note: ''*If an episode receives points for diabetic ulcers, it cannot also receive points for ''Non-pressure and non-stasis ulcers.''

13. On page 49854, in the fourth column of Table 10B, in lines 7 and 8, revise ''(PRIMARY OR FIRST OTHER DIAGNOSIS = 250.8x AND PRIMARY OR FIRST OTHER DIAGNOSIS = 707.10–707.9).'' to read ''(PRIMARY DIAGNOSIS = 250.8x AND OTHER DIAGNOSIS = 707.10–707.9).''

14. On page 49855, in the second column of Table 10B, below ICD–9–cm code 946.5, insert ''948''. In addition, in column 4 of Table 10B, insert the short description of ICD–9–CM code 948 directly under the short description of code 946.5. The short description for 948 should read, ''BURN CLASS ACCORD–BODY SURF INVOLVED''.

15. On page 49855, in the first column of Table 10B, delete the word ''Care'' from the Diagnostic Category titles for ICD–9–CM codes V55.5, V55.0, and V55.6. In addition, in the fourth column of Table 10B, delete the word ''CARE'' from the Short Descriptions for ICD–9–CM codes V55.5 and V55.0.

16. On page 49868, in Table 12, in the second column, the CY 2007 per-visit amount ''121.22'' for speech-language pathology, is corrected to read ''121.32''. In addition, in the fifth column, the CY 2008 per-visit amount ''124.54'' for speech-language pathology is corrected to read ''124.65.''

17. On page 49870, on the bottom of the page, beginning in the first column, remove the language that begins with ''Outlier payments are determined'' through page 49871, in the third column, line 26 that ends with ''episode, including the outlier payment.'' Replace the previous outlier example with the following:

Outlier payments are determined and calculated using the same methodology that has been used since the implementation of the HH PPS.

Example 3 details the calculation of an outlier payment.

Example 3. Calculation of an Outlier Payment

The outlier payment amount is the product of the imputed amount in excess of the outlier threshold absorbed by the HHA and the loss sharing ratio. The outlier payment is added to the sum of the wage and case-mix adjusted 60-day episode amount. The steps to calculate the total episode payment, including an outlier payment, are given below.

For this example, assume that a beneficiary lives in Greenville, SC and that the episode in question began and ended in CY 2008. The episode has a case-mix severity = C3F3S5, and is a second episode with 98 visits (40 skilled nursing, 45 home health aide visits, and 13 physical therapy visits). The beneficiary had 105 NRS points, for an NRS severity level = 6. Therefore, from Table 9, the NRS payment amount = $551.00; from Table 5, the case-mix weight = 1.9413; and from Addendum B, the wage index = 0.9860.

1. Calculate case-mix and wage-adjusted 60-day episode payment, including NRS.

National standardized 60-day episode payment amount for episodes beginning and ending in CY 2008

= $2,270.32

Calculate the case-mix adjusted episode payment:

Multiply the national standardized 60-day episode payment by the applicable case-mix weight:

$2,270.32 × 1.9413 = $4,407.37

Divide the case-mix adjusted episode payment into the labor and non-labor portions:

Labor portion: 0.77082 × $4,407.37 = $3,397.29

Non-labor portion: 0.22918 × $4,407.37 = $1,010.08

Wage-adjust the labor portion by multiplying it by the wage index factor for Greenville, SC:

0.9860 × $3,397.29 = $3,349.73

Add wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted 60-day episode payment before NRS added:

$3,349.73 + $1,010.08 = $4,359.81

Add NRS amount to get the total case-mix and wage-adjusted 60-day episode payment, including NRS:

$551.00 + $4,359.81 = $4,910.81

2. Calculate wage-adjusted outlier threshold.

Fixed dollar loss amount = national standardized 60-day episode payment multiplied by 0.89 FDL:

$2,270.32 × 0.89 = $2,020.58

Divide fixed dollar loss amount into labor and non-labor portions:

Labor portion: 0.77082 × $2,020.58 = $1,557.50

Non-labor portion: 0.22918 × $2,020.58 = $463.08

Wage-adjust the labor portion by multiplying the labor portion of the fixed dollar loss amount by the wage index:

$1,557.50 × 0.9860 = $1,535.70

Calculate the wage-adjusted fixed dollar loss amount by adding the wage-adjusted portion of the fixed dollar loss amount to the non-labor portion of the fixed dollar loss amount:

$1,535.70 + $463.08 = $1,998.78

Add the case-mix and wage-adjusted 60-day episode amount including NRS and the wage-adjusted fixed dollar loss amount to get the wage-adjusted outlier threshold:

$4,910.81 + $1,998.78 = $6,909.59

3. Calculate the wage-adjusted imputed cost of the episode.

Multiply the total number of visits by the national average per-visit amounts listed in Table 12:

40 skilled nursing visits × $104.91 = $4,196.40

45 home health aide visits × $47.51 = $2,137.95

13 physical therapy visits × $114.71 = $1,491.23

Calculate the wage-adjusted labor and nonlabor portions for the imputed skilled nursing visit costs:

Labor portion: 0.77082 × $4,196.40 = $3,234.67

Non-labor portion: 0.22918 × $4,196.40 = $961.73

Adjust the labor portion of the skilled nursing visits by the wage index:

0.9860 × $3,234.67 = $3,189.38

Add the wage-adjusted labor portion of the skilled nursing visits to the non-labor portion for the total wage-adjusted imputed costs for skilled nursing visits:

$3,189.38 + $961.73 = $4,151.11

Calculate the wage-adjusted labor and non-labor portions for the imputed home health aide visits:

Labor portion: 0.77082 × $2,137.95 = $1,647.97

Non-labor portion: 0.22918 × $2,137.95 = $489.98

Adjust the labor portion of the home health aide visits by the wage index:

0.9860 × $1,647.97 = $1,624.90

Add the wage-adjusted labor portion of the home health aide visits to the non-labor portion for the total wage-adjusted imputed costs for home health aide visits:

$1,624.90 + $489.98 = $2,114.88

Calculate the wage-adjusted labor and non-labor portions for the imputed physical therapy visits:

Labor portion: 0.77082 × $1,491.23 = $1,149.47

Non-labor portion: 0.22918 × $1,491.23 = $341.76

Adjust the labor portion of the physical therapy visits by the wage index:

0.9860 × $1,149.47 = $1,133.38

Add the wage-adjusted labor portion of the physical therapy visits to the non-labor portion for the total wage-adjusted imputed costs for physical therapy visits:

$1,133.38 + $341.76 = $1,475.14

Total wage adjusted imputed per-visit costs for skilled nursing, home health aide, and physical therapy visits during the 60-day episode:

$4,151.11 + $2,114.88 + $1,475.14 = $7,741.13

4. Calculate the amount absorbed by the HHA in excess of the outlier threshold.

Subtract the outlier threshold from (2) from the total wage-adjusted imputed per-visit costs for the episode from (3).

$7,741.13 − $6,909.59 = $831.54

5. Calculate the outlier payment and total episode payment.

Multiply the imputed amount in excess of the outlier threshold absorbed by the HHA from (4) by the loss sharing ratio of 0.80:

$831.54 × 0.80 = $665.23 = outlier payment

Add the outlier payment to the case-mix and wage-adjusted 60-day episode payment, including NRS, calculated in (1):

$665.23 + $4,910.81 = $5,576.04

$5,576.04 equals the total payment for the episode, including the outlier payment.

18. On page 49873, in Table 14, in the second column, the CY 2007 per-visit amount ''121.22'' for speech-language pathology, is corrected to read ''121.32''. In addition, in the fifth column, the CY 2008 per-visit amount ''122.13'' for speech-language pathology is corrected to read ''122.23''.

19. On page 49877, in the first column of Table 15, under the impacts by ''Type of Facility'', revise the group name ''Subtotal: Vol/PNP'' to read ''Subtotal: Vol/NP''.

20. On page 49880, in Addendum A, in the third column, in line 7, the entry ''1.1283'' that is displayed as the wage index for CBSA code 07 (rural Connecticut) is corrected to read ''1.1711''.

21. On page 49881, in the footnote at the bottom of Addendum A, CY 2007 is corrected to read CY 2008. Additionally, we are correcting the footnote at the bottom of Addendum A to read, ''[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for CY 2008. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as for CY 2007.

22. On page 49890, in Addendum A, in the third column, the entry ''0.9353'' that is displayed as the wage index for CBSA code 16180 (Carson City, NV) is corrected to read ''1.0003''.

23. On page 49901, in Addendum B, in the third column, the entry ''1.0937'' that is displayed as the wage index value for CBSA code 25540 (Hartford-West Hartford-East Hartford, CT) is corrected to read ''1.0930''.

24. On page 49901, in Addendum B, the reference to the footnote for CBSA 25980 and on page 49932 the actual footnote are corrected to read ''1''.

25. On page 49918, in Addendum B, in the third column, the entry ''1.0959'' that is displayed as the wage index for CBSA code 39900 (Reno-Sparks, NV) is corrected to read ''1.0715''.

26. On pages 49933, in Addendum C, in the fourth column, in line 7, the entry ''1.1283'' that is displayed as the wage index for CBSA code 07 (rural Connecticut) is corrected to read ''1.1711''. In addition, on page 49933, in Addendum C, in the fifth column, in line 7, the entry of ''−3.64'' that is displayed as the percent change from CY 07 to CY 08 for CBSA 07 is corrected to read ''0.02''.

27. On page 49936, in Addendum C, in the fourth column, in line 14 from the bottom, the entry of ''0.9353'' that is displayed as the wage index for CBSA code 16180 (Carson City, NV) is corrected to read ''1.0003''. In addition, on page 49936, in the fifth column, the entry ''−6.70'' that is displayed as the percent change from CY 07 to CY 08 for CBSA 16180 is corrected to read ''−0.22''.

28. On page 49939, in Addendum C, in the fourth column, in line 3, the entry ''1.0937'' that is displayed as the wage index for CBSA code 25540 (Hartford-West Hartford-East Hartford, CT) is corrected to read ''1.0930''. In addition, on page 49939, in the fifth column, in line 4, the entry ''0.39'' that is displayed as the percent change from CY 07 to CY 08 for CBSA 25540 is corrected to read ''0.33''.

29. On page 49943, in Addendum C, in the fourth column, the entry of ''1.0959'' that is displayed as the wage index for CBSA code 39900 (Reno-Sparks, NV) is corrected to read ''1.0715''. In addition, on page 49943, in the fifth column, the entry ''−8.39'' that is displayed as the percent change from CY 07 to CY 08 for CBSA 39900 is corrected to read ''−10.43''.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice such as this take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive both the notice and comment procedure and the 30-day delay in effective date if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

We find for good cause that it is unnecessary to undertake notice and comment rulemaking because this notice merely provides typographical and technical corrections to the regulations. We are not making substantive changes to our payment methodologies or policies, but rather, are simply implementing correctly the payment methodologies and policies that we previously proposed, received comment on, and subsequently finalized. The public has already had the opportunity to comment on these payment methodologies and policies, and this correction notice is intended solely to ensure that the CY 2008 HH PPS final rule accurately reflects them. Therefore, we believe that undertaking further notice and comment procedures to incorporate these corrections into the CY 2008 HH PPS final rule is unnecessary and contrary to the public interest.

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

Dated: November 27, 2007.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. E7–23272 Filed 11–29–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 65

[Docket No. FEMA–B–7750]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the Base (1% annual-chance) Flood Elevations (BFEs) is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified BFEs for new buildings and their contents.

DATES: These modified BFEs are currently in effect on the dates listed in the table below and revise the Flood Insurance Rate Maps (FIRMs) in effect prior to this determination for the listed communities.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Mitigation Assistant Administrator of FEMA reconsider the changes. The modified BFEs may be changed during the 90-day period.

ADDRESSES: The modified BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: William R. Blanton, Jr., Engineering Management Section, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3151.

SUPPLEMENTARY INFORMATION: The modified BFEs are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified BFE determinations are available for inspection is provided.

Any request for reconsideration must be based on knowledge of changed conditions or new scientific or technical data.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified BFEs are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by the other Federal, State, or regional entities. The changes BFEs are in accordance with 44 CFR 65.4.

National Environmental Policy Act. This interim rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This interim rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This interim rule involves no policies that have federalism implications under Executive Order 13132, Federalism.

Executive Order 12988, Civil Justice Reform. This interim rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

■ 1. The authority citation for part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.